1

12653

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12758 Item 7 File 275 11-28-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7124 - Maple Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

074

3. NAME OF DECEASED (Type or print): First: Nettie Middle: P. Last: Adams,
4. DATE OF DEATH: Month: Nov. Day: 14 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/15/77
9. AGE (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE Retired
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME None
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: XX SAMUEL Pinkham
14. MOTHER'S MAIDEN NAME: UNKNOWN ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no.
17. INFORMANT: Clinton W. Adams Address: 4/8 - Quaint Acres Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs
DUE TO (b): Arteriosclerosis — ?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Operated for carcinoma of colon 11/11/60
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 to 14 Nov 1960 that (I) (we) last saw the deceased alive on 11/12 1960 and that death occurred at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William D. Aud M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/14/60
22c. PHYSICIAN'S NAME (Type): WILLIAM D. AUD
22d. ADDRESS: 9006 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/17/60
23c. NAME OF CEMETERY OR CREMATORY: NAT'L MEM. PARK CEMETERY
23d. LOCATION (City, town, or county) (State): FALLS CHURCH VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE: NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12759

CERTIFICATE OF DEATH

12654

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 19 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 12906 — Georgia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clayton — Middle: T. — Last: Bacher, SR.
4. DATE OF DEATH: Month: Nov. — Day: 15 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/30/08
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months — Days. IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lt.
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Special Police
11. BIRTHPLACE (State or foreign country): Burlington, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK A. BACHER
14. MOTHER'S MAIDEN NAME: HILDA B. FROHARDT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Dorothy M. Bacher, 12,906 Ga. Ave. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic shock — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.
DUE TO (b) Left pleural effusion — 4 weeks.
DUE TO (c) Probable Carcinoma Primary Site unknown — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Calcific aortic stenosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from — 1955 to Nov 15 1960, that (I) (we) last saw the deceased alive on Nov 15 1960, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Blaine H. Fig, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Blaine H. Fig
22d. ADDRESS: 8041 Colesville Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/18/60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. HUMPHREY, INC. Raymond A. Fiske
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE: NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted]ed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12679 **CERTIFICATE OF DEATH** Reg. Dist. No. 12655

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13,004 Flack Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 SILVER SPRING
d. STREET ADDRESS 13,004 Flack Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ~~XXXXXXXX~~ MARY JEANNE Middle Last BAUSCH
4. DATE OF DEATH Month NOV Day 9 Year 1960
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/24/47
9. AGE (In years last birthday) 13 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME EUGENE M. BAUSCH
14. MOTHER'S MAIDEN NAME MARY WILKINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Mr. Eugene M. Bausch, 13,004 Flack Street Address Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory depression — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b) Brain damage — years
DUE TO
(c) Hydrocephalus — 13 years

752X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Extremely small vital capacity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1960, to Nov, 1960, that I last saw the deceased alive on October, 1960, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Richard P. Delaney M.D. ADDRESS (Street, city or town, state) 4323 Howard St DATE SIGNED 11/10/60

PHYSICIAN'S NAME (Type) RICHARD P. DELANEY, MD Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 11/11/60
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jiska ADDRESS SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE NOV 14 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12760 12656

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 104 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 401 C Street N.W. 47X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 050

3. NAME OF DECEASED (Type or print): First: Peggy Middle: Ann Last: Beavers

4. DATE OF DEATH: Month: November Day: 3 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: April 5 1940
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Not employed
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: Rufus Beavers
14. MOTHER'S MAIDEN NAME: Lona Fuller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 229-52-3002
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia and Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b) Acute lymphocytic leukemia — 15 months
DUE TO
(c)

2043

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 22 1960 to November 3 1960, that (I) (we) last saw the deceased alive on November 3 1960 and that death occurred at 5:30 PM from the causes and on the date stated above.

22a. SIGNATURE: Vincent H Bono Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11/ 4/ 60
22c. PHYSICIAN'S NAME (Type): Vincent H Bono, Jr., M.D.
22d. ADDRESS: The Clinical Center National Institutes Of Health, Bethesda 14 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: Nov 4 1960
23c. NAME OF CEMETERY OR CREMATORY: Richland Va
23d. LOCATION (City, town, or county) (State): Richland Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter Deal Funeral 4812 Ga Ave NW
25a. REC'D BY REGISTRAR — DATE: NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Christine S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

F2742

CERTIFICATE OF DEATH

Reg. Dist. No. 12657

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marylander Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 52
d. STREET ADDRESS: 3116 Rolling Rd. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: A — Last: Beeler
4. DATE OF DEATH: Month: Nov. — Day: 2 — Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1878
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hickey
14. MOTHER'S MAIDEN NAME: Anna Ryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Mrs Thomas E Walker, Chevy Chase, Md — Address: 3116 Rolling Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/3, 1960 to 10/2, 1960 that I last saw the deceased alive on 10/29, 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. — ADDRESS (Street, city or town, state): Damascus, Md — DATE SIGNED: 11/1/60
PHYSICIAN'S NAME (Type): James P. Kerr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/5/60
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cem
22d. LOCATION (City, town, or county) (State): Hawthorne NJ

23. FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home — ADDRESS: 5108 Wisconsin Ave Washington DC
24a. REC'D BY REGISTRAR: DATE NOV 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12761

12658

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RD1, Gaithersburg
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RD1, Gaithersburg
d. STREET ADDRESS: (RD1, Gaithersburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ANNIE Middle: Elizabeth Last: BELL
4. DATE OF DEATH: Month: Nov. Day: 1, Year: 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Mar. 21, 1877
9. AGE (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Fannie Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter: Minnie Tyler, Address: RD1 Gaithersburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b) Cardiac Decompensation — 4 yrs.
DUE TO (c) Coronary Occlusion — 4 yrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis - cerebro-vascular occlusion
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1955, 19__ to Nov. 1, 1960, that (I) (we) last saw the deceased alive on 10-31, 1960, and that death occurred at 2 A M, from the causes and on the date stated above.

22a. SIGNATURE: Clive E. Jackson, M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-1-60
22c. PHYSICIAN'S NAME (Type): Clive E. Jackson
22d. ADDRESS: 202 Martin La., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/4/60
23c. NAME OF CEMETERY OR CREMATORY: Brooke Grove.,
23d. LOCATION (City, town, or county) (State): Laytonsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snyder
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: NOV 3 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12762

CERTIFICATE OF DEATH

12659

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 33 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 BETHESDA
d. STREET ADDRESS: 4008 Bradley Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle W — Last BELL
4. DATE OF DEATH: Month 11/2/60 — Day — Year 19
5. SEX: Male White
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/14/85
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Nathan Bell
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daughter Miss Emma Bell Same as Item 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular collapse
DUE TO
(b) mesenteric thrombosis with myocardial infarction — 12 hrs.
DUE TO
(c) arteriosclerotic heart disease — 6 days
420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1957 to Nov. 2 1960 that (I) (we) last saw the deceased alive on Nov 2 1960 and that death occurred at P. M. from the causes and on the date stated above.

22a. SIGNATURE: Wilfred R. Ehrmentraut M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov
22c. PHYSICIAN'S NAME (Type): Wilfred R. Ehrmentraut M.D.
22d. ADDRESS: 4890 Battery Lane, Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): xxxxxxxx
23b. DATE THEREOF: 11/5/60
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.
23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300-4th St. N.E.
25a. REC'D BY REGISTRAR DATE NOV 4 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12763 12660

CERTIFICATE OF DEATH

M

090

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 59 Bethesda
d. STREET ADDRESS: 8200 Rayburn Road, Wheaton Md.
e. IS RESIDENCE ON A FARM? NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Anne — Last: Belyea
4. DATE OF DEATH: Month: November — Day: 11 — Year: 1960
5. SEX: F
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 6, 1867
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Jessie Crowse
14. MOTHER'S MAIDEN NAME: Eunice M. Sprague
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Florence Tisdale-daughter-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis, Generalized — INTERVAL BETWEEN ONSET AND DEATH: 10+ yrs.
422.1
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-21- 1960 to 11-11- 1960 that (I) (we) last saw the deceased alive on 11-10 1960, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Whitlock M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-11-60
22c. PHYSICIAN'S NAME (Type): James M. Whitlock MD
22d. ADDRESS: 2717 Cornell Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 11/15/60
23c. NAME OF CEMETERY OR CREMATORY: Needham Cemetery
23d. LOCATION (City, town, or county) (State): Boston, Massachusetts

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: NOV 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,12 FilmG276 12-9-60 et

12743

CERTIFICATE OF DEATH

Reg. Dist. No. 12661

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall N. H.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 2900 Terrace Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella; Middle: Blanche; Last: Bishop

4. DATE OF DEATH: Month: November; Day: 20; Year: 1960

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 24, 1873

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired telegrapher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hillsbor, New Brunswick, Canada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: E. Chipman Bishop

14. MOTHER'S MAIDEN NAME: Susan Eliza

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 010-03-6406A

17. INFORMANT: Col. Herbert B. Nichols — Address: 2900 Terrace Dr. Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): Arterio sclerosis generalized
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypostatic pneumonitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov., 1954, to Nov 20, 1960, that I last saw the deceased alive on Nov 17, 1960, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred S. Norton, M.D. — ADDRESS (Street, city or town, state): 4711 Highland Ave Bethesda Md. — DATE SIGNED: 11/20/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): transportation & Burial

22b. DATE THEREOF: 11-22-60

22c. NAME OF CEMETERY OR CREMATORY: St. James Church

22d. LOCATION (City, town, or county) (State): Cambridge, Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: Ives Funeral Home, Inc. — ADDRESS: Arlington, Virginia

24a. REC'D BY REGISTRAR DATE: NOV 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12702 Item 6 Film 6215 11-22-60 et 12662

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4104 Isabell STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: (WMN) — Last: Blaser

4. DATE OF DEATH: Month: 11 — Day: 15 — Year: 1960

5. SEX: Fe

6. COLOR OR RACE: White — Hebrew

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-13-88

9. AGE (In years lost birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: Ralph Goldseller

14. MOTHER'S MAIDEN NAME: Amelia ~~[illegible]~~ Moritz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b) Coronary Thrombosis — Hours
DUE TO
(c) Chronic congestive heart failure — Years

434.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 3 1960 to November 14 1960 that (I) (we) last saw the deceased alive on Nov. 14 1960 and that death occurred at 12:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ABRAHAM W DANISH

22d. ADDRESS: 927 Pershing Dr. Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11/17/60

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Pk

23d. LOCATION (City, town, or County) (State): Falls Church Va

24. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home — ADDRESS: 4217 9 St. N.W.

25a. REC'D BY REGISTRAR: DATE NOV 17 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12764

CERTIFICATE OF DEATH

12663

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmore Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS: 3173 Porter Street, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle Last BONWIT

4. DATE OF DEATH: Month November Day 2 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1882
9. AGE (In years lost birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amnon Behrend
14. MOTHER'S MAIDEN NAME: Sarah Behrend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
INFORMANT: Mrs. Edgar Stromberg
Address: 3173 Porter St., N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis + hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO
(b) cerebral arteriosclerosis — 1-5 yrs
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Jan 1950, to Nov 2, 1960, that I last saw the deceased alive on 10/26, 1960, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R Wilner M.D. ADDRESS (Street, city or town, state): 2500 Calvert St N.W Wash DATE SIGNED:

PHYSICIAN'S NAME (Type): PAUL R. WILNER, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-6-60
22c. NAME OF CEMETERY OR CREMATORY: Washington Hebrew Cong. Cem.
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Danzansky & Sons
ADDRESS: 3501 14th St., NW
24a. REC'D BY REGISTRAR DATE NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12765 **CERTIFICATE OF DEATH** 12664

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 1/2 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3903 Oliver Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: A. — Last: Brand
4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-20-79
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Brand
14. MOTHER'S MAIDEN NAME: Fannie Glenn Stewart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lillian Brand — Sister — 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
Immediate cause (a): Acute congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 12 M.
DUE TO
(b): Myocardial insufficiency — 1+ yr.
DUE TO
(c): Coronary arteriosclerosis — 5+ yr.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): chronic pulmonary fibrosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5 Nov 1960 to 10 Nov 1960, that (I) (we) last saw the deceased alive on 10 Nov 1960 and that death occurred at 5 p.m., from the causes and on the date stated above.

22a. SIGNATURE: A. H. Richwine, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8 Nov 60
22c. PHYSICIAN'S NAME (Type): A. H. RICHWINE
22d. ADDRESS: 5522 Western Ave. Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/14/60
23c. NAME OF CEMETERY OR CREMATORY: Greenhill Cemetery
23d. LOCATION (City, town, or county) (State): Luray, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12766

CERTIFICATE OF DEATH

12665

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 3225 S. Utah Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

051

3. NAME OF DECEASED (Type or print): First: Diana; Middle: Lyman; Last: BRANDT

4. DATE OF DEATH: Month: November; Day: 22; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-20-60

9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR: Months; Days: 2; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. BRANDT, JR.

14. MOTHER'S MAIDEN NAME: Aileen ALLEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (F) Geo. E. Brandt, Jr., same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IMMATURITY
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Nov. 20, 1960 to Nov. 22, 1960, that (I) (we) last saw the deceased alive on Nov. 22, 1960, and that death occurred at 3:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-22-60

22c. PHYSICIAN'S NAME (Type): Robert V. RACK, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-25-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey L.N. — ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.

25a. REGISTRY REGISTRAR: NOV 28 60 — DATE

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

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12767

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.U.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 4205 Independence Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wellington — Middle: Cicero — Last: Brannon
4. DATE OF DEATH: Month: November — Day: 21 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 17, 1881
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Landscape artist-retired
10b. KIND OF BUSINESS OR INDUSTRY: Knight & Bostwick Co.
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Albert Brannon
14. MOTHER'S MAIDEN NAME: Hattie L. Gilbert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: (Son-in-law) J.U. Deaton — Address: As above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.0
DUE TO (b): Arteriosclerotic Heart disease — Unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19__, to 11-21, 1960, that (I) (we) last saw the deceased alive on 11-20, 1960, and that death occurred at 12:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Morris Perry M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-21-60
22c. PHYSICIAN'S NAME (Type): Morris Perry
22d. ADDRESS: 11602 Georgia Ave. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/23/60
23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.
24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Gaska — WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR — DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12768

CERTIFICATE OF DEATH

Reg. Dist. No. 12667

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 32 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10815 Jewett St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 074 I 0 1

3. NAME OF DECEASED (Type or print): First: Louise; Middle: M.; Last: BRENNAN
4. DATE OF DEATH: Month: Nov.; Day: 28; Year: 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 18 1898
9. AGE (In years lost birthday): 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: LINDERMUTH
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: John J. Shandis (Grandson) — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.0
DUE TO (b) Arteriosclerotic Heart Disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10/27, 1960, to 11/28, 1960, that I last saw the deceased alive on 11/28, 1960, and that death occurred at 6:45 pm M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Timothy J. Tehan — M.D. — ADDRESS (Street, city or town, state): 8218 Wisconsin Ave. Bethesda Md. — DATE SIGNED: 11/28/60

PHYSICIAN'S NAME (Type): TIMOTHY J. TEHAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/1/60
22c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
22d. LOCATION (City, town, or county) (State): Pottsville, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR: DATE DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12769

CERTIFICATE OF DEATH

12668

M

074

I

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: [illegible] COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS: 924 Upshur Street N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: Biggs Last: Bright
4. DATE OF DEATH: Month: Nov. Day: 6 Year: 1960
5. SEX: M
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/19/65
9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanical engineer
10b. KIND OF BUSINESS OR INDUSTRY: Navy Dept.
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Bright
14. MOTHER'S MAIDEN NAME: unknown.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Oscar P. Mast — Address: 924 Upshur St. N.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Edema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 5 1960 to Nov 6 1960 that (I) (we) last saw the deceased alive on Nov 6 1960, and that death occurred at 4½ P.M., from the causes and on the date stated above.

22a. SIGNATURE: George Sharpe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 6 1960
22c. PHYSICIAN'S NAME (Type): George Sharpe
22d. ADDRESS: 10511 Summit Ave Kensington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11/9/60
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12770

CERTIFICATE OF DEATH

Reg. Dist. No. 12669

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 165 Hampton St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard; Middle: J.; Last: Brogden

4. DATE OF DEATH: Month: 11; Day: 12; Year: 1960

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-30-1912
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Charles Brogden
14. MOTHER'S MAIDEN NAME: Margaret Pratt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-09-5165
INFORMANT: Letitia (wife) Address: 1344 D St NE Wash. DC.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral
DUE TO (b): Recurrent bronchogenic carcinoma Right Lung
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
162.1
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19, 1960, to Nov 12, 1960, that I last saw the deceased alive on Nov 12, 1960, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A. Beeman M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave. Silver Spring, Md. DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-17-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. ZION,
22d. LOCATION (City, town, or county) (State): Mt. ZION, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Brewer ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE: NOV 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

12703

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12670

M

075

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible]ed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7124 Maple Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lenore; Middle: (NMN.); Last: Brown
4. DATE OF DEATH: Month: Nov.; Day: 2; Year: 1960
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-29-85
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Houey
14. MOTHER'S MAIDEN NAME: Mary Dodge
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: U.S. Hosp. Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b) Bronchopneumonia — 5 days
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diaphragmatic hernia, Fracture of spine
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Oct 17, 1960, to Nov. 2, 1960, that (I) (we) last saw the deceased alive on Nov 1, 1960, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/2/60
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 918 Univ. Blvd. E., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 5, 1960
23c. NAME OF CEMETERY OR CREMATORY: Danby Cemetery
23d. LOCATION (City, town, or county) (State): Danby Michigan

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters by DAV
ADDRESS: 254 Carroll St. N.W. Washington 12, D.C.
25a. REC'D BY REGISTRAR: DATE NOV 4 60
25b. REGISTRAR'S SIGNATURE: Arthur S. Adams

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12771 12671

CERTIFICATE OF DEATH

Items 2 Film G275 11-28-60 et Items 8 G276, 12/2/60, et

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Missouri~~ Md. b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Springfield 3U01-4
d. STREET ADDRESS: 1326 Ensor Street ~~United States Federal Penitentiary~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie Middle: Lee Last: Brown

4. DATE OF DEATH: Month: November Day: 14 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: ~~1934~~ March 29, 1929

9. AGE (In years last birthday): 26 31 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank Brown

14. MOTHER'S MAIDEN NAME: Neomi (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: Unascertainable

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anoxic Brain Damage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Cardiac Arrest with Asystole - 8 minutes 11-10-60

DUE TO (c): Acute Intermittent Porphyria — 20 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

289.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 29, 1960 to November 14, 1960 that (I) (we) last saw the deceased alive on November 14, 1960, and that death occurred at 4:53 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11/15-60

22c. PHYSICIAN'S NAME (Type): Emanuel S. Hellman, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/17/60

23c. NAME OF CEMETERY OR CREMATORY: Carvel Mem. Park

23d. LOCATION (City, town, or county) (State): Laurel, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers

ADDRESS: 1400 Chapin St. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: NOV 18 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

and Chas. B. Lewis, 1639 N. Broadway, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12772

CERTIFICATE OF DEATH

12672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

074

1

0

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Chevy Chase
d. STREET ADDRESS: 6648 Hillandale Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Belle; Middle: T.; Last: Bump
4. DATE OF DEATH: Month: 11; Day: 22; Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/3/1893
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Edward Tupper
14. MOTHER'S MAIDEN NAME: Martha Howe
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Merle J. Bump, husband — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Approx. 2 yrs
420.0
DUE TO (b) Arteriosclerotic heart disease — 2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from October 19 60 to Nov. 22 19 60, that (I) (~~we~~) last saw the deceased alive on Nov. 22, 19 60, and that death occurred at 3:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George A. Graff Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/22/60
22c. PHYSICIAN'S NAME (Type): George A. Graff JR. MD
22d. ADDRESS: 4750 Chevy Chase 15, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 11/23/60
23c. NAME OF CEMETERY OR CREMATORY: Ulysses Cemetery
23d. LOCATION (City, town, or county): Ulysses, Penna. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12753

CERTIFICATE OF DEATH

12673

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12,815 Caldwell Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 12,815 Caldwell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEARL; Middle ELIZABETH; Last BURKE

4. DATE OF DEATH: Month NOV.; Day 16; Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/27/85

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Clerk - retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN A. SEILER

14. MOTHER'S MAIDEN NAME: MAGDELINE SUMMERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. Raymond J. Greenich, 3324 Clay St. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
(b) Suspected abdominal malignancy (not confirmed) Deceased refused hospitalization — unknown
DUE TO
(c)

199.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 15 Nov 1960, to 16 Nov 1960, that (I) (we) last saw the deceased alive on 15 Nov 1960, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 18 Nov 60

22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR

22d. ADDRESS: 5029 Bethesda Ave, Beth. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11/19/60

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

23d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeska
WARNER E. PUMPHREY, INC.
ADDRESS: SILVER SPRING, MD.

25a. REC'D BY REGISTRAR DATE NOV 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 18 Film 276 12-8-60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12773 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12674

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 hrs. 45 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X Sandy Spring
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: Antonia — Last: Burriss

4. **DATE OF DEATH**: Month: November — Day: 9 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/1/60
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months 7, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Margaret Burriss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT**: Hospital Records, Address: Olney, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
527.0
DUE TO (b): Pulmonary Atelectasis & edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Died while undergoing right inguinal hernia repair under ether anesthesia.
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/9/60
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/11/60
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial Cemetery
22d. LOCATION (City, town, or country) (State): Sandy Springs Md.

23. FUNERAL DIRECTOR: Robert L. Snavden — ADDRESS: Rockville Md
24a. REC'D BY REGISTRAR: DATE NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2073265 XV3

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12774

12675

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle BUTTRY — Last
4. DATE OF DEATH: Month NOVEMBER — Day 7 — Year 19 60

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/9/79
9. AGE (In years lost birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TENN.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lum C. Buttry
14. MOTHER'S MAIDEN NAME: GETTY LOUISE BUTTRY

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOSPITAL RECORDS, Address: OLNEY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO (b)
DUE TO (c)

002X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from August, 1956, to November 7, 1960, that (I) (we) last saw the deceased alive on November 7 1960, and that death occurred at 11:06 A M, from the causes and on the date stated above.

22a. SIGNATURE: G F Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/7/60
22c. PHYSICIAN'S NAME (Type): G. F. MEADORS, M. D.
22d. ADDRESS: DAMASCUS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-10-60
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City, town, or county) (State): Gaithersburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner — ADDRESS: Gaithersburg Md
25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12775 12676

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON, MD
c. LENGTH OF STAY IN 1b: 16 da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WHEATON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): University Park 1664-2
d. STREET ADDRESS: 4314 Colesville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH Middle F. Last CAMPBELL
4. DATE OF DEATH: Month Nov Day 16 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 18 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, U.S.P.O. Dept.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Campbell
14. MOTHER'S MAIDEN NAME: Catherine Clancy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. M.J. Casey Address: niece

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs.
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1 1960 to Nov. 16 1960, that (I) (we) last saw the deceased alive on Nov. 15 1960, and that death occurred at 3:20 AM from the causes and on the date stated above.

22a. SIGNATURE: A. Thibadeau M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A. F. Thibadeau
22d. ADDRESS: 10111 Colesville Rd. Silver Spring Md.

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: burial
23b. DATE THEREOF: 11/18/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: S.H. Hines Co ADDRESS: 2901-14th St. N.W. Wash, D.C.
25a. REC'D BY REGISTRAR DATE NOV 17 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kramer M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12776

CERTIFICATE OF DEATH

12677

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: No. 1 Port Green, S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4-7X-3

M

051

3. NAME OF DECEASED (Type or print): First: Kelly — Middle: Ann — Last: CARPENTER

4. DATE OF DEATH: Month: November — Day: 29 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-26-60

9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR: Months: — Days: 3 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: James Earl CARPENTER

14. MOTHER'S MAIDEN NAME: Ann Marie MAHAR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (F) James E. Carpenter, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 70 HOURS.

754.5

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (we) (this hospital) attended the deceased from Nov. 26, 1960 to Nov. 29, 1960 that (I) (we) last saw the deceased alive on Nov. 29 1960, and that death occurred at 8:38PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-30-60

22c. PHYSICIAN'S NAME (Type): Robert V. RACK, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-2-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Mac H. Morris — ADDRESS: Arlington, Va.
Arlington Funeral Home, 3901 N. Fairfax Drive,

25a. REC'D BY REGISTRAR: DEC 1 '60 — DATE

25b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible]d by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

Mas

2051293XV7

Montgomery District of Columbia

Bethesda (Naval) 3 days Washington

U. S. Naval Hospital No. 1 Fort Green, S.W.

Kelly Ann CARPENTER November 29 50

Female Deceased 11-29-50 3

- - - - - - - - - - - - - - - - Maryland U.S.A.

James Earl CARPENTER Ann Marie KEHAS

No - - - - None (?) James E. Carpenter, same as #2 above

Nov. 29 50 Nov. 29 50 x

x

Robert V. MASK, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 12-2-50 Arlington National Arlington Virginia

Arlington, Va.

Arlington Funeral Home, 3201 N. Wakefield Drive,

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

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VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12777 12678

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY, MD.
c. LENGTH OF STAY IN 1b: D O A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 320 EAST MONTGOMERY AVE.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle HAIG — Last CARTER
4. DATE OF DEATH: Month NOVEMBER — Day 22 — Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6/25/1888
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MASSACHUSETTS
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN I. CAIG
14. MOTHER'S MAIDEN NAME: DELIA A. CUMMINGS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: 218-14-5928
17. INFORMANT: HOSPITAL RECORDS, OLNEY, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2½ hrs.
DUE TO (b) Rupture of abdominal aortic aneurysm
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): F. J. BROSCHART, M. D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 11/23/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-26-60
22c. NAME OF CEMETERY OR CREMATORY: Rockville Union
22d. LOCATION (City, town, or country): Rockville (State): Md.

23. FUNERAL DIRECTOR: Ernest Gartner — ADDRESS: Gaithersburg Md.
24a. REC'D BY REGISTRAR: DATE NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12778 **CERTIFICATE OF DEATH** 12679

M

073

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 34 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG
d. STREET ADDRESS: R-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle ELLEN Last CAUFIELD
4. DATE OF DEATH: Month NOVEMBER Day 26, Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOVEMBER 3, 1865
9. AGE (In years lost birthday): 95 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home Work
11. BIRTHPLACE (State or foreign country): Clopper Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: WILLIAM R. HUTTON
14. MOTHER'S MAIDEN NAME: MARY AUGUSTA CLOPPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: HOSPITAL RECORDS, OLNEY, MARYLAND Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH
422.2
DUE TO (b) Chronic Myocarditis.
~~DUE TO~~ (c) Uremia.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 19 to 11/26 19 60 that (I) (we) last saw the deceased alive on 11/25 19 60 and that death occurred at 4:35A M, from the causes and on the date stated above.

22a. SIGNATURE: Lucius L. Leal, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L. I. LEAL, M. D.
22d. ADDRESS: GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-29-60
23c. NAME OF CEMETERY OR CREMATORY: St, Rose
23d. LOCATION (City, town, or county) (State): Clopper. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[redacted]d by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

Heart Failure
Chronic Hypokinetic.
— Uremia.

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12680 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12680

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9914 Capitol View Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Silver Spring
d. STREET ADDRESS: 9914 Capitol View Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vernie; Middle: Gertrude; Last: Chapman
4. DATE OF DEATH: Month: 11; Day: 13; Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-10-84
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Hysell
14. MOTHER'S MAIDEN NAME: Matilda Lyon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give year or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Raymond Chapman (son) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Cerebral vascular accident — 2 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-13-60

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 11/16/60
22c. NAME OF CEMETERY OR CREMATORY: Beech Grove Cemetery
22d. LOCATION (City, town, or country) (State): Pomeroy, Meigs County, Ohio

23. FUNERAL DIRECTOR: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
Raymond A. Zieka
24a. REC'D BY REGISTRAR: DATE NOV 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12081

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN Hp
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5001 Aurora St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Kensington
d. STREET ADDRESS: 15001 Aurora St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nicholas; Middle: Joseph; Last: Cibula
4. DATE OF DEATH: Month: Nov; Day: 9; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-24-60
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months / Days: 17; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Doctors Hospital, Wash. D.C. Md
12. CITIZEN OF WHAT COUNTRY? U.S.C.
13. FATHER'S NAME: Joseph Cibula
14. MOTHER'S MAIDEN NAME: Patricia Douglas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Jos. Cibula -father- Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
763.0
DUE TO (b): upper Respiratory Infection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/12/60
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem
22d. LOCATION (City, town, or country) (State): Silver Spring, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Inspector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12704 **CERTIFICATE OF DEATH** 12682

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 407 Elm Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Addie Middle: Viola Last: Clapp

4. DATE OF DEATH Month: 11 Day: 29 Year: 1960

5. SEX: Female **6. COLOR OR RACE:** White **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7-13-69

9. AGE (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H W.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: Wm. Henry Dean
14. MOTHER'S MAIDEN NAME: Ella Hollister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b) Arteriosclerotic heart disease — unknown
DUE TO (c) Generalized arteriosclerosis — unknown

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 11/19 1960 to 11/29 1960 that (I) (~~we~~) last saw the deceased alive on 11/29 1960, and that death occurred at 10:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/29/60
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 918 Univ. Blvd. E. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 2, 1960
23c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON
23d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY MD

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE DEC 2 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Kerns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12779

CERTIFICATE OF DEATH

Reg. Dist. No. 12683

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, R.F.D

c. LENGTH OF STAY IN 1b 1 Month

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dickerson,

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle Joseph Last Clements

4. DATE OF DEATH Month November Day 30 Year 1960

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH June, 6-1882

9. AGE (In years lost birthday) 78 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Henry L. Clements

14. MOTHER'S MAIDEN NAME Nellie M. Nicholson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 579-20-3902

INFORMANT Address Mrs Regina Kibler, Gaithersburg, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

420.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary arteriosclerosis — 6 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Jan 1950, to Nov. 30, 1960 that I last saw the deceased alive on Nov 29, 1960, and that death occurred at 5:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Vernon E. Martens M.D. ADDRESS (Street, city or town, state) Germantown, Md DATE SIGNED Dec 1. 60

PHYSICIAN'S NAME (Type) Vernon E. Martens Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Dec 3-1960

22c. NAME OF CEMETERY OR CREMATORY Monocacy

22d. LOCATION (City, town, or county) (State) Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton ADDRESS Barnesville, Md

24a. REC'D BY REGISTRAR DATE DEC 6 '60

24b. REGISTRAR'S SIGNATURE Gordon E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12780 12684

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Chevy Chase
d. STREET ADDRESS: 4705 De Russey Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Lost: Cole
4. DATE OF DEATH: Month: November Day: 1 Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 12/16/77
9. AGE (In years lost birthday): 82 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Pittsburg, Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Cole
14. MOTHER'S MAIDEN NAME: Mary Jane McCauley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 208-01-8779
17. INFORMANT: Miss Gretchen Cole (daughter) Address: See Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-7, 1960 to 10/1/, 1960 that (I) (we) last saw the deceased alive on 10/31 1960, and that death occurred at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul D. Cantor M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/1/60
22c. PHYSICIAN'S NAME (Type): Paul D. Cantor
22d. ADDRESS: 4709 Montgomery Lane, Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11/1/60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 2 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12705

CERTIFICATE OF DEATH

12685

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 12 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4502 Mahan Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: Elmer — Last: Collingwood

4. DATE OF DEATH: Month: 11 — Day: 25 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-19-04

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photo Operator

10b. KIND OF BUSINESS OR INDUSTRY: The Osso. Press

11. BIRTHPLACE (State or foreign country): Washington State

12. CITIZEN OF WHAT COUNTRY? Amer

13. FATHER'S NAME: ORLANDO ~~Rex~~ Byrd Collingwood

14. MOTHER'S MAIDEN NAME: Elizabeth ~~XXXXXXXXX~~ LESLIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.: 366-10-2197

INFORMANT: (wife) Mrs Ida Collingwood — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA (TERMINAL) AND ATELECTASIS — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
DUE TO (b): BRONCHOGENIC CARCINOMA WITH — (PROBABLE) 9 MONTHS
DUE TO (c): CARCINOMATOSIS

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from OCT 12, 1960, to NOV 25, 1960 that I last saw the deceased alive on NOV 24, 1960, and that death occurred at 3:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L. Krichmar M.D. — ADDRESS (Street, city or town, state): 7733 ALASKA AVE N.W. — DATE SIGNED: NOV 25 1960

PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR M.D. — WASHINGTON 12. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11/28/60

22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond E. Gates — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR: DATE DEC 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12686

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 5 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 12000 Denny Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 12000 Denny Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (SARAH) Rosaria Middle Last Crivella
4. DATE OF DEATH: Month Nov Day 18 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-10-1871
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy
13. FATHER'S NAME: Joseph Citrano
14. MOTHER'S MAIDEN NAME: Rose Maisiglia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel Crivella (son) Address 1908 Stratton Rd Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: hrs

260X

DUE TO (b) Diabetes Mellitus — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
Address (Street, city, town, or county):
DATE SIGNED: 11-18-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-22-60
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
22d. LOCATION (City, town, or country) (State): WASH. D.C.

23. FUNERAL DIRECTOR: Timothy Hanlon
ADDRESS: 3831 Ga Ave NW
24a. REC'D BY REGISTRAR: NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Items 18&20 Film 278 1963

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12706 12687

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: D.O.A

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash San + Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton 34

d. STREET ADDRESS: 13129 Holdridge Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kathy Middle: Jeane Last: Croker

4. DATE OF DEATH: Month 11 Day 15 Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-30-60

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: 1 Days: 16 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dist of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John V Croker

14. MOTHER'S MAIDEN NAME: Kay Cancelliere

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Kay Croker Address: same as deceased

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) asphyxia

DUE TO

924.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Blankets pulled against face when baby was alone in carriage.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Autopsy disclosed no other abnormalities contributing to death

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ XX

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) The baby was left alone in crib in car for ½ hr. about 3PM, 11/15/60. When mother returned baby was not breathing. She was rushed to a local MD and sent at once to Wash. San.

20c. TIME OF INJURY Hour 3 p.m. Month, Day, Year 11/15 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): near Home

20f. (City or town) Silver Spring (County) Montg (State) Md.

21. I **certify** that (I) (this hospital) attended the deceased from 4-30 1960 to 11/15 1960 that (I) (we) last saw the deceased alive on 11/15 1960 and that death occurred at 4 PM, from the causes and on the date stated above.

22a. SIGNATURE: George R. Spence M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): GEORGE R. SPENCE

22d. ADDRESS: 1515 HIGHLAND DRIVE SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 11/18/60

23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY

23d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD. Raymond A. Giska

25a. REC'D BY REGISTRAR DATE NOV 22 '60

25b. REGISTRAR'S SIGNATURE: Chitwood S Kuma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

Mons

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12782 **CERTIFICATE OF DEATH** 12688

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 11 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. STREET ADDRESS: 6704 Floyd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: Girl — Last: DANIEL
4. DATE OF DEATH: Month: November — Day: 17 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-60
9. AGE (In years lost birthday) yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 11 — Min.: 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Royal Thomas DANIEL, JR.
14. MOTHER'S MAIDEN NAME: Lillian Martha ELLIS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (F) R. T. Daniel, Jr., same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital diaphragmatic hernia — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5603

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov. 16 1960 to Nov. 17 1960, that (I) (we) last saw the deceased alive on Nov. 17 1960, and that death occurred at 9:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: C W Bramlett M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-17-60
22c. PHYSICIAN'S NAME (Type): C.W.BRAMLETT, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-18-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR — DATE: NOV 18 '60
25b. REGISTRAR'S SIGNATURE: Lillian S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

M 051 I 2

205136 5XV6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

CERTIFICATE OF DEATH

Reg. Dist. No. 12680

1. PLACE OF DEATH a. COUNTY Montgomery ~~7702 Old Chester Rd.~~ MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Montgomery~~

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7702 Old Chester Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. b. COUNTY D.C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3

d. STREET ADDRESS 6402 16th St. N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Walter Middle Wright Last Deal

4. DATE OF DEATH Month Nov. Day 5 Year 1960

5. SEX Male

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH April 2 1886

9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director

10b. KIND OF BUSINESS OR INDUSTRY Funeral Director

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John F. Deal

14. MOTHER'S MAIDEN NAME Mary Ann Roycroft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

17. INFORMANT Address Anna Hall 7702 Old Chester Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) advanced coronary sclerosis — 2 yrs

DUE TO (c) severe generalized arteriosclerosis — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1955, to 11/5, 1960, that I last saw the deceased alive on 11/4, 1960, and that death occurred at 5:27 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE D B Washington M.D. ADDRESS (Street, city or town, state) 6234 Ga Ave NW Wash DC DATE SIGNED 11/5/60

PHYSICIAN'S NAME (Type) Daniel B. Washington M.D. 6234 Ga. Ave N.W. Wash DC.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Nov. 8 1960

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State) Prince Geo. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Deal Funeral Home 4812 Ga. Ave.

24a. REC'D BY REGISTRAR DATE NOV 14 '60

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754

CERTIFICATE OF DEATH

Reg. Dist. No. 12690

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN 1b 4½ Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12118 Galena Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 12118 Galena Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First VITO Middle (NMN) Last De FILIPPIS
4. DATE OF DEATH Month November Day 2nd, Year 1960
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 21st, 1870
9. AGE (In years lost birthday) 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason (retired)
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? Italy
13. FATHER'S NAME John De Filippis
14. MOTHER'S MAIDEN NAME Mary Manicone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Address John DeFilippis, 304 S. Highland St. Arlington, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b) Carcinoma intestine — 6 mos
DUE TO
(c)

153.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/15/60, 19____, to 11/2/60, 19____, that I last saw the deceased alive on 11/1/60, 19____, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Patrick C. Jameson M.D. ADDRESS (Street, city or town, state) 1202 Georgia Ave. DATE SIGNED 11/2/60

PHYSICIAN'S NAME (Type) Patrick C. Jameson

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/5/1960
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State) Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W.Chambers Co. 517--11th St.S.E.Wash.DC
24a. REC'D BY REGISTRAR DATE NOV 7 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12784 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12691

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Monty Gen Hosp

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Genevieve — Middle: Estelle — Last: Demar
4. DATE OF DEATH: Month: Nov — Day: 12 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-9-32
9. AGE (In years last birthday): 28 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Hilary Demar
14. MOTHER'S MAIDEN NAME: Bertha Stewart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Columbus Demar — Address: Gaith. R-1 Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Bullet wound Thru heart
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

981X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shotgun left chest with 25 cal revolver
20c. TIME OF INJURY: Hour 7:15 p.m. — Month, Day, Year: 11-12 1960
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Church yard
20f. (City or town): Mt Zion — (County): Monty — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-13-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-16-60
22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove,
22d. LOCATION (City, town, or country): Laytonsville, Md. (State)
23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE: NOV 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12785 Reg. Dist. No. 12692

M

074

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1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Bethesda
d. STREET ADDRESS: 5614 Wilson Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Luther; Middle: L; Last: Derrick

4. DATE OF DEATH: Month: 11; Day: 17; Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9-18-70

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: 1; Days: 29 — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painting Decorator

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: John Derrick

14. MOTHER'S MAIDEN NAME: Christine Dominick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 262-50-2033

INFORMANT: John M. Derrick (son) Address: 1401 Brandywine St. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
420.1
DUE TO
(b) Coronary arteriosclerosis, advanced — 10 yrs +
DUE TO
(c) Arteriosclerosis, generalized — 10 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial Infarction 1952

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1952 to Nov 17, 1960, that I last saw the deceased alive on Nov 16, 1960, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp M.D. — ADDRESS (Street, city or town, state): 4740 Chevy Chase Dr. — DATE SIGNED: 11/17/60

PHYSICIAN'S NAME (Type): Stewart Clapp — Chevy Chase 15 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/19/60

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR: DATE NOV 18 '60

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12786 Item 2 FilmG275 11-29-60 et

Reg. Dist. No. 12693

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Maryland~~ D.C. b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Washington
d. STREET ADDRESS: 4816-5th St., N. W. ~~12201 Rockville Pike~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: E. Last: Diggins
4. DATE OF DEATH: Month: 11 Day: 16 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/25/82
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U. S. GOVT.
11. BIRTHPLACE (State or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Eli Luckett
14. MOTHER'S MAIDEN NAME: Annie Agnes Holloran
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Louis Diggins (son) Address: 1312 Coral Sea, Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLISM — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
903.7
DUE TO
(b) PERIPHERAL VENOUS THROMBOSIS — DAYS
DUE TO
(c) FRACTURE, RIGHT FEMUR — 8 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on floor of nursing Home
20c. TIME OF INJURY Hour 6 p.m. Month, Day, Year 11-8-1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home
20f. (City or town) Rockville (County) Montg (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-17-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-19-60
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: F. J. Collins
FRANCIS J. COLLINS
ADDRESS: WASH. D.C. 3821 14TH. ST. N.W.
24a. REC'D BY REGISTRAR DATE: NOV 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12787

CERTIFICATE OF DEATH

Reg. Dist. No. 12694

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Keyser
d. STREET ADDRESS: Rural Delivery # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

858-3

3. NAME OF DECEASED (Type or print): First: Frank; Middle: (none); Last: Domenic
4. DATE OF DEATH: Month: November; Day: 4; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 11, 1914
9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Antonio Domenic
14. MOTHER'S MAIDEN NAME: Pauline Scarpone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 217-10-7124
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Aortic Stenosis & Insufficiency, post operative — 20 hours
DUE TO (c): Rheumatic Heart Disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

411 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Atelectasis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 2, 1960, to November 4, 1960, that I last saw the deceased alive on November 4, 1960, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Awe MD M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 11/4/60

PHYSICIAN'S NAME (Type): William C. Awe, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-7-60
22c. NAME OF CEMETERY OR CREMATORY: St Thomas
22d. LOCATION (City, town, or county): Keyser — (State): W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE: J.H.Markwood & Sons — ADDRESS: Keyser.West Va.
24a. REC'D BY REGISTRAR: DATE NOV 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12707

CERTIFICATE OF DEATH

12695

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3½ mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 517 Albany Avenue Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 12
d. STREET ADDRESS: 1514 Van Buren St N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGIA Middle: C. Last: DONNAN

4. DATE OF DEATH: Month: 11 Day: 15 Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19, 1871
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry Coggins
14. MOTHER'S MAIDEN NAME: Zalina Rowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Dusinberre (daughter) Address: 1514 Van Buren St. Washington 12 DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
DUE TO
(b) Generalized Arteriosclerosis — 25 yrs
DUE TO
(c)

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1 1945 to Nov 15 1960 that (I) (we) last saw the deceased alive on Oct 19 1960, and that death occurred at 11 A M, from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn. Ave Kensington Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/18/60
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: S.H. Hines Co. ADDRESS: 2901 14th St NW
25a. REC'D BY REGISTRAR DATE: NOV 16 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12708

CERTIFICATE OF DEATH

Reg. Dist. No. 12696

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
c. LENGTH OF STAY IN 1b: Life.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
d. STREET ADDRESS: 16833 Eastern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

X

3. NAME OF DECEASED (Type or print): First WILLARD Middle RAYMOND Last DOUGLAS

4. DATE OF DEATH: Month Nov. Day 23 Year 1960

5. SEX: Male
6. COLOR OR RACE: Wh.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 8, 1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Purchasing agent - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward M. Douglas.
14. MOTHER'S MAIDEN NAME: Zilpha Childs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Wife - Mrs Marguerite Douglas — Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, esophagus. — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

150 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —
20f. (City or town) (County) (State): —

1

21. I certify that I attended the deceased from Dec, 1957 to Nov 23, 1960, that I last saw the deceased alive on Nov 23, 1960, and that death occurred at 6:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William F. Simpson, Jr. M.D. — ADDRESS (Street, city or town, state): 6216 N.H. Ave N.E. — DATE SIGNED: 11/23/60

PHYSICIAN'S NAME (Type): William F. Simpson, Jr. Washington, DC.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: Nov 26, 1960
22c. NAME OF CEMETERY OR CREMATORY: GLENWOOD CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

27. FUNERAL DIRECTOR'S SIGNATURE: Herbert Walker — ADDRESS: 254 CARROLL ST. N.W. WASH D.C.
24a. REC'D BY REGISTRAR: DATE NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

CERTIFICATE OF DEATH

Reg. Dist. No. 12697

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Althea Woodland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY: 47X-S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON DC
d. STREET ADDRESS: 2400 Wyoming Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRMA Middle: E Last: DRAYTON

4. DATE OF DEATH: Month: 11 Day: 11 Year: 1960

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-19-1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chestertown, Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Thomas W. Eliason
14. MOTHER'S MAIDEN NAME: Violet Bris Coe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
INFORMANT: Nursing Home Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia (terminal) — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
450.0
DUE TO
(b) generalized arteriosclerosis — 10 yrs
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 3, 1960 to Nov 11, 1960 that I last saw the deceased alive on 11-11, 1960, and that death occurred at 10/15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hill Carter M.D. — ADDRESS (Street, city or town, state): 1835 Eye St NW — DATE SIGNED: Nov. 60

PHYSICIAN'S NAME (Type): HILL CARTER — Wash D C

22a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: burial
22b. DATE THEREOF: 11/14/60
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., ADDRESS: 2901 14th St. N.W. Wash, D.C.
24a. REC'D BY REGISTRAR: DATE NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12682

CERTIFICATE OF DEATH

12698

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 University Blvd. East

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 21
d. STREET ADDRESS 122 University Blvd. East
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Mildred Middle: Pearl Last: Eby

4. DATE OF DEATH Month: Nov. Day: 5 Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 24, 1875
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Stull
14. MOTHER'S MAIDEN NAME: Marietta Armacost

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
INFORMANT: Henry R. Eby Address: 122 University Blvd. East Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Ascending Colon — INTERVAL BETWEEN ONSET AND DEATH: 3 years.
153.0
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Metastasis to Liver & Lymph nodes Inguinal
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec. 27, 1958, to Nov. 5, 1960, that I last saw the deceased alive on Nov. 4, 1960, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Wardrop M.D. ADDRESS (Street, city or town, state): 800 Pershing Drive Silver Spring DATE SIGNED: 11/8/60

PHYSICIAN'S NAME (Type): W. B. WARDROP 800 PERSHING DRIVE SILVER SPRING

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/8/60
22c. NAME OF CEMETERY OR CREMATORY: Wesley Cemetery
22d. LOCATION (City, town, or county) (State): Rural Hampstead, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr. ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR: DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12788 **CERTIFICATE OF DEATH** 12699

M

074

I

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BARNESVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WINFIELD Middle: SCOTT Last: EDWARDS
4. DATE OF DEATH Month: Nov. Day: 8 Year: 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1876
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - County Rd, Montgo
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. J.R. Lillard Address: Barnesville, Md (Friend)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONJECTIVE HEART FAILURE
DUE TO
(b) OLD C.V.A
DUE TO
(c)

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10/20 1960 to 11/7 1960, that (I) (we) last saw the deceased alive on Nov 8 1960, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward A. Beeman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): EDWARD BEEMAN
22d. ADDRESS: 10620 GEORGIA AVE. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/10/60
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City, town, or county) (State): Buellsville Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. B. Hilton ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

12700

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, MD
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE, MD
d. STREET ADDRESS: 5814 30TH AVE 1680-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LISA Middle ANN Last EHRLICH

4. DATE OF DEATH: Month NOV Day 12 Year 19 60

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/7/60

9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months / Days 5 — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT A. EHRLICH

14. MOTHER'S MAIDEN NAME: CAROL ANN ADAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ROBERT EHRLICH — Address: 5814 30TH AVE HYATTSVILLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
776X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. NONE 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/7, 1960, to 11/12, 1960, that I last saw the deceased alive on 11/12, 1960, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stanley L. Blumenthal M.D. — ADDRESS (Street, city or town, state): 10620 Georgia Ave, Silver Spring, Md. — DATE SIGNED: Nov 12 1960

PHYSICIAN'S NAME (Type): STANLEY L. BLUMENTHAL — 10620 GEORGIA AVE, SILVER SPRING, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 11-12-60

22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium & Hospital

22d. LOCATION (City, town, or county) (State): Takoma Pk. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M.D. — ADDRESS: Washington San. & Hosp.

24a. REC'D BY REGISTRAR DATE: NOV 16 60

24b. REGISTRAR'S SIGNATURE: Arthur S. Flemming

2075193XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12789

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12701

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9113 Gue Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Burtonsville
d. STREET ADDRESS: Blackburn Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles Middle: Franklin Last: Elliott

4. DATE OF DEATH: Month: Nov. Day: 2 Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/8/97

9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter - Norman

10b. KIND OF BUSINESS OR INDUSTRY: L. Elliott Construction Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Marshall Elliott

14. MOTHER'S MAIDEN NAME: Myrtle Frances Kidwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: 215-26-3520

17. INFORMANT Address: Norman L. Elliott, Burtonsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

Address (Street, city, town, or county):

DATE SIGNED: Nov. 2, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11/5/60

22c. NAME OF CEMETERY OR CREMATORY: Burtonsville Union Cemetery

22d. LOCATION (City, town, or country) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR: WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.

Raymond A. Zirka

24a. REC'D BY REGISTRAR DATE: NOV 9 '60

24b. REGISTRAR'S SIGNATURE: Carlton S. Knauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12790

CERTIFICATE OF DEATH

12702

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 32 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 58 Cabin John
d. STREET ADDRESS: 6431 - 79th. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Noble — Middle: B. — Last: Embrey
4. DATE OF DEATH: Month: Nov. — Day: 30 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11/15/82
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret - U.S. Gov't
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov'T
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: MILTON FRANCIS EMBREY
14. MOTHER'S MAIDEN NAME: MARY ELIZABETH CAYWOOD.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-32-4521
INFORMANT: Silver Spring, Md. — Address: Niece Mrs. P. Clark-2317 Blueridge Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Pulmonary embolism — 2 days
DUE TO (c) Thrombosis, Right Auricular Appendage — days

434.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from NOV 1, 1960, to NOV 30, 1960, that I last saw the deceased alive on NOV 30, 1960, and that death occurred at 7:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A. Beeman M.D. — ADDRESS (Street, city or town, state): 10620 GEORGIA AVE., SILVER SPRING, MD — DATE SIGNED: 11/30/60
PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/5/60
22c. NAME OF CEMETERY OR CREMATORY: Potomac Church Cem.
22d. LOCATION (City, town, or county) (State): Potomac, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 6 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

CERTIFICATE OF DEATH

Reg. Dist. No. 12703

M

075

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): D.C. 47X-3
d. STREET ADDRESS: 3111 Newton St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lore; Middle: Ann; Last: ENNIS

4. DATE OF DEATH: Month: 11; Day: 2; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 31, 1960

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: ; Days: 2 IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Patrick Ennis

14. MOTHER'S MAIDEN NAME: Loretta Evelyn Carpenter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mothers Chart — Address: 3111 Newton St. NE. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Anoxia
DUE TO
(b):
DUE TO
(c):

762.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to 11/2, 1960, that I last saw the deceased alive on 11/2, 1960, and that death occurred at 6 a.m. p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: H H Diamond M.D.
ADDRESS (Street, city or town, state): 919 Silver Spring Ave
DATE SIGNED:
PHYSICIAN'S NAME (Type): H. H. DIAMOND — Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-4-60

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or county): Washington (State): D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The D.H. Hess Co. ADDRESS: 2901-14th St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE NOV 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

207518 IXV6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

CERTIFICATE OF DEATH

Reg. Dist. No. 12704

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 23 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 822 Underwood St NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle:; Last: Epstein
4. DATE OF DEATH: Month: 11; Day: 7; Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-1893
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Playland
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Maurice Epstein
14. MOTHER'S MAIDEN NAME: Mary Aipsitz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 212-18-5106
INFORMANT: Lee Epstein (wife) Address: 822 Underwood St NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days
420-1
DUE TO
(b): Coronary Arteriosclerosis — 3 years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 17, 1955 to Nov 7, 1960 that I last saw the deceased alive on Nov 7, 1960, and that death occurred at 9:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John J Curry M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave DATE SIGNED: 11/21/60
PHYSICIAN'S NAME (Type): Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-9-1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town or county) (State): Fort Meyer Va
23. FUNERAL DIRECTOR'S SIGNATURE: Frank Geiers Sons Co ADDRESS: 3605-14 St NW Wash. D.C.
24a. REC'D BY REGISTRAR DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12744 12705

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensingto n
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 39
d. STREET ADDRESS: 10,411 Amherst Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle K. M. Last EWING
4. DATE OF DEATH: Month November Day 1 Year 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/25/78
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Alien Property Custodian U.S. Gov't.
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Ewing
14. MOTHER'S MAIDEN NAME: Virginia Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Spanish American
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Kathleen E. Daly, S. Egremont, Mass. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: App. 6 wks
DUE TO
(b) Generalized Arteriosclerosis
DUE TO
(c) Small Cerebral Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct 25, 19 60 to Nov. 1, 19 60 that (I) (we) last saw the deceased alive on Nov 1, 19 60, and that death occurred at 2:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 1, 1960
22c. PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D.
22d. ADDRESS: 10609 Concord St., Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/3/60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Giska
WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 4 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12711

CERTIFICATE OF DEATH

Reg. Dist. No. 12706

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 29 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi 1656-2
d. STREET ADDRESS: 7900 New Riggs Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

075

3. NAME OF DECEASED (Type or print): First: SHERI Middle: LYNNE Last: FARABEE

4. DATE OF DEATH: Month: 11 Day: 14 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11/13/60

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months —, Days — IF UNDER 24 HRS.: Hours 29, Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Takoma Park, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

I

13. FATHER'S NAME: Ronald Warner Farabee

14. MOTHER'S MAIDEN NAME: Libby Sue Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mother Address: Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: Since Birth
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from birth, 19____, to 11/14, 1960, that I last saw the deceased alive on 11/14/60, 19____, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Winston E. Cochran M.D.

PHYSICIAN'S NAME (Type): Dr. Winston E. Cochran 927 Pershing Dr. Silver Springs, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 17. 1960

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Wallace ADDRESS: 254 Carroll St. NW DC

24a. REC'D BY REGISTRAR DATE: NOV 17 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2075201XV4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG275 11-22-60 et

12745

CERTIFICATE OF DEATH

Reg. Dist. No. 12707

1. PLACE OF DEATH
a. COUNTY: Montgomery. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 4 1/2 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sant.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 41
d. STREET ADDRESS: 9500 Byeford Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: ; Last: Farrell

4. DATE OF DEATH: Month: Nov.; Day: 2; Year: 1960

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 8, 1875

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ritchey

14. MOTHER'S MAIDEN NAME: Elizabeth Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Farrell Address: 9500 Byeforde Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
465X
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture Left hip (femur) Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pt. apparently fell

20c. TIME OF INJURY: Hour ? a. m. p. m.; Month: 10; Day: 11; Year: 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Nursing home

20f. (City or town): Kensington (County): Mont. (State): Md.

21. I certify that I attended the deceased from July, 1960, to Oct. 30, 1960, that I last saw the deceased alive on Oct. 30, 1960, and that death occurred at 12:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G Lenard Gold M.D. ADDRESS (Street, city or town, state): Eig Building Silver Spring Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): G. Lenord Gold M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 5 1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county): Washington D. C. (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Deal Funeral Home ADDRESS: 4812 Ga. Ave.

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

M

090

I

Coroner notified and refused jurisdiction

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

CERTIFICATE OF DEATH

Reg. Dist. No. 12708

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 14 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: 75 X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 6433 N. Broad St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA Middle: L. Last: Feldstein

4. DATE OF DEATH: Month: 11 Day: 30 Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-3-1883
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Lohren
14. MOTHER'S MAIDEN NAME: Ernestine Weider

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Babette A. Lohren — Address: daughter in law 103 10 Colesville Rd. S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs
DUE TO (b) Hypertension
DUE TO (c)

330 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 29, 1960, to Nov 30, 1960, that I last saw the deceased alive on Nov 29, 1960, and that death accurred at 8:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard A Fitzgerald M.D. — ADDRESS (Street, city or town, state): 217 University Blvd E — DATE SIGNED: 11-30-60

PHYSICIAN'S NAME (Type): Bernard A Fitzgerald — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 11/30/60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hoare

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

M 074

Certificate has been notified and the approval release

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12712 12709

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4101 Everett St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: (NMN) Last: Field
4. DATE OF DEATH: Month: 11 Day: 26 Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/24/85
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housf
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): I llo
12. CITIZEN OF WHAT COUNTRY? AMT.
13. FATHER'S NAME: FRANK Kosnick
14. MOTHER'S MAIDEN NAME: Augusta Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Pt Chart Address: Records Washington Sanitarium & Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion – Art. acute	11 hrs
420.1 DUE TO (b)	Arteriosclerosis	? years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Hypertension	? years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955 19__ to Nov. 26 1960, that (I) (we) last saw the deceased alive on Nov 25 1960, and that death occurred at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert A Hare, MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Robert A Hare MD
22d. ADDRESS: 809 Davis Ave, Takoma Pk. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/28/60
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Fiska
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE DEC 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12713 12710

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2003 Grace Church Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: Ola — Last: Fincham

4. DATE OF DEATH: Month: 11 — Day: 19 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-2-12
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Onw home
11. BIRTHPLACE (State or foreign country): XXXX, WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roy C. Gooding
14. MOTHER'S MAIDEN NAME: XXXXXXXXXXXXXXXX NELLIE M. NEWLON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE XXXXXXXXXXXXX
17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Cerebellar infarction and necrosis — INTERVAL BETWEEN ONSET AND DEATH

∃32X

DUE TO (b) Rt cerebellar arterial occlusion — about 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Cerebellar arterial sclerosis — years -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked pulmonary atelectasis - Pelvic Surgery 11-17-60

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-10-1960, to 11-19-, 1960, that (I) (we) last saw the deceased alive on 11-19-1960 and that death occurred at 8:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Read N. Calvert M.D. — ATTENDING PHYS. ☑ (Surgeon) MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11-19-60
22c. PHYSICIAN'S NAME (Type): READ N. CALVERT, M.D.
22d. ADDRESS: 7894 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/22/60
23c. NAME OF CEMETERY OR CREMATORY: GLENWOOD CEMETERY
23d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. — Raymond A. Fiska — ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12714 12711

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 2029 Rittenhouse St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 099

3. NAME OF DECEASED (Type or print): First: Carl; Middle: Dotterer; Last: Foreman

4. DATE OF DEATH: Month: 11; Day: 11; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct 18, 1900

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Naval Weapons

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: American

13. FATHER'S NAME: ALBERT FOREMAN

14. MOTHER'S MAIDEN NAME: MARTHA DOTTERER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Edla Foreman — Address: West Hyattsville, 2029 Rittenhouse St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

O

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

2

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

DATE SIGNED: 11-11-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 11/14/60

22c. NAME OF CEMETERY OR CREMATORY: George Washington Mem. Cem.

22d. LOCATION (City, town, or country) (State): Hyattsville, Md.

23. FUNERAL DIRECTOR: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE NOV 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12793 Item 8 FilmG279 1-16-61 et

Reg. Dist. No. 12712

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Warren
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waterlick
d. STREET ADDRESS: Rt.2, R.F.D.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

83 X 3

3. NAME OF DECEASED (Type or print): First: Roger; Middle: Royce; Last: Frederick

4. DATE OF DEATH: Month: Nov. 3; Day; Year: 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 5, 1924

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David Fredrick

14. MOTHER'S MAIDEN NAME: Dellinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1941-45

16. SOCIAL SECURITY NO.:

17. INFORMANT: Barbara Drederick, wife, as above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intrapontine hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
901.6
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fall from ladder — 27 hours
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Skull fracture with subdural and epidural hematoma. Epilepsy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have fallen from ladder while painting

20c. TIME OF INJURY Month, Day, Year: 1960 Nov. 2 Hour a. m. p. m.: 3:15

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bldg.

20f. (City or town): Washington D.C. (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bischart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 11-4-60

EXAMINER'S NAME (Type): FRANK J. Bischart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/6/60

22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

22d. LOCATION (City, town, or county) (State): Strasburg, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Strasburg, Va.

24a. REC'D BY REGISTRAR DATE: NOV 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

TO DEPU

MINER: This certificate should be executed within 24 hours after death. If any y is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page retained for your files. Examiner's Office along with form PM3. Page 5 ma State Board of Health,

FOR ST
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12713 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12713

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville, Md.
d. STREET ADDRESS: 2118 Ravenswood Street 1658-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernard; Middle: Mason; Last: Funk, Sr.
4. DATE OF DEATH: Month: 11; Day: 1; Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/25/18
9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master gas fitter
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ~~Frederick Funk~~ FREDERICK FUNK
14. MOTHER'S MAIDEN NAME: Dora A. Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: 577-12-7593
17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration
DUE TO (b) bullet wound in skull
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 13 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound in right skull
20c. TIME OF INJURY: Hour 10:25 a.m. p.m. — Month, Day, Year: 10/31 19 60
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): son's home
20f. (City or town): West Hyatts. (County): P.G. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/1/60
EXAMINER'S NAME (Type): Frank J. Broschart,
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/4/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery
22d. LOCATION (City, town, or country): Arlington, Virginia (State)
23. FUNERAL DIRECTOR: WARNER E. PUMPHREY, INC. — Raymond A. Zicka — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE NOV 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MEDICAL EXA... please execute the certificate, writing ... 4 should be forwarded to the Chief Medical ... TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the ... or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15ME
M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12714

1279 Items 11,12 Film 275 11-22-60 et

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: - - -
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4548 Windsor Lane, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4548 Windsor Lane,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia Middle: A Last: Gardner

4. DATE OF DEATH: Month: November Day: 15 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Geologist (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Chamberlain, S.D.
12. CITIZEN OF WHAT COUNTRY? - U.S.A.

13. FATHER'S NAME: Charles Gardner
14. MOTHER'S MAIDEN NAME: Julia M. Brackett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: 578-48-7426
17. INFORMANT: Remsen B. Ogilby (Attorney) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Cerebral Vessel Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 Days
332
DUE TO (b): Cerebral Arteriosclerosis — 7 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemiplegia Left - 1953

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 1, 1953 to Nov. 15, 1960 that (I) (~~we~~) last saw the deceased alive on Nov. 12 1960 and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank S. Bacon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): FRANK S. BACON
22d. ADDRESS: 1150 Conn. Ave. N.W.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11-18-1960
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlaiski Inc.
ADDRESS: 1756 Pa. Ave. N.W. Wash. 6, D.C.
25a. REC'D BY REGISTRAR DATE NOV 17 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12755

CERTIFICATE OF DEATH

Reg. Dist. No. 12715

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7708 Fortune Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 7708 Fortune Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle BEALL Last GARRETT

4. DATE OF DEATH: Month November Day 11, Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 1/12/75
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John H. Garrett
14. MOTHER'S MAIDEN NAME: Alcinda Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: McKendree G. Fulks Address Rt. # 2 Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.
DUE TO
(b) Chronic bronchitis — 5 years
DUE TO
(c)

502.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fracture left femur - (fell in room) not contributory to death
20c. TIME OF INJURY Month, Day, Year: Dec. 22 1957 Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Rockville (County) Montgomery Co. (State) Md.

21. I certify that I attended the deceased from about 1940 19____, to Nov. 11 1960 that I last saw the deceased alive on Nov. 10 1960, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm A. Linthicum M.D. ADDRESS (Street, city or town, state): 110 S. Washington St. Rockville, Md. DATE SIGNED: 11/11/60

PHYSICIAN'S NAME (Type): William A. Linthicum

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/14/60
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Tyson Wheeler Funeral Home 331 E. Montgomery Ave., Rockville, Md.
24a. REC'D BY REGISTRAR DATE: NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12795 12716

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville
c. LENGTH OF STAY IN 1b 1 Year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16550 Emory Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rockville
d. STREET ADDRESS 16550 Emory Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Andrew Middle Last Gaul
4. DATE OF DEATH Month Nov. Day 29 Year 19 60
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 17 1877
9. AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inventor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New ~~Jersey~~ Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew Gaul
14. MOTHER'S MAIDEN NAME Elizabeth Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 121 18 0706
17. INFORMANT Katherine Mather Address Same As 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — 1wk.
DUE TO (b) Carcinoma of prostate with metastases
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X — 2yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, generalized
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/26 1960 to 11/29 1960, that (I) (we) last saw the deceased alive on 11/29 1960, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE C. H. Lipson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/29/60
22c. PHYSICIAN'S NAME (Type) C. H. LIPSON
22d. ADDRESS Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Bremoval
23b. DATE THEREOF Dec. 2 1960
23c. NAME OF CEMETERY OR CREMATORY Maple Grove Park
23d. LOCATION (City, town, or county) Hackensack (State) New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE DEC 1 '60
25b. REGISTRAR'S SIGNATURE Clifton S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12683

CERTIFICATE OF DEATH

12717

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1 year, 10 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Althea Woodland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5441 Nebraska Ave. N.W.
d. STREET ADDRESS: Washington, D. C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel; Middle: ; Last: Gauntlett

4. DATE OF DEATH: Month: 11; Day: 21; Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct-5-1876

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: 11; Days: 21
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?: Great Britain

13. FATHER'S NAME: Charles Gauntlett

14. MOTHER'S MAIDEN NAME: Georgana Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: MR. JOHN A. FRANCIS (NEPHEW) Address: 5441-NEBRASKA AVE, N. W.-WASH. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7 mo.
DUE TO (b)
DUE TO (c)

15 > X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1945, to Nov. 21, 1960, that I last saw the deceased alive on Nov. 19, 1960, and that death occurred at 10:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas A. Wildman, M.D. M.D.
ADDRESS (Street, city or town, state): 3729 Morrison St, N.W. Washington 15, DC
DATE SIGNED: 11-21-60
PHYSICIAN'S NAME (Type): Thomas A. Wildman M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/23/1960
22c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: MARTIN W. HYSONG COMPANY
ADDRESS: 1300 N. STREET, N. W. WASH. D.C.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12796

CERTIFICATE OF DEATH

12718

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bradford Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 408 Mulberry St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eliza — Middle: Jane — Last: Gibson
4. DATE OF DEATH: ~~March~~ November 15 1960

5. SEX: Fem
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4.15.00
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY: housework
11. BIRTHPLACE (State or foreign country): Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Dorsey B Mayers
14. MOTHER'S MAIDEN NAME: Jane Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-26-3747
INFORMANT: Lillian Powell daughter — Address: Oakerest. Laurel Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorenal Disease Coronary Thrombosis — INTERVAL BETWEEN ONset AND DEATH: 1 day
420.1
DUE TO (b) Hemiplegia
DUE TO (c) arteriosclerotic Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 2, 1960, to Nov 15, 1960, that I last saw the deceased alive on Nov. 14, 1960, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Webster Sewell M.D. — ADDRESS (Street, city or town, state): Norbeck — DATE SIGNED:
PHYSICIAN'S NAME (Type): WEBSTER SEWELL — Rt 1 Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 18/60
22c. NAME OF CEMETERY OR CREMATORY: Bloom Chapel
22d. LOCATION (City, town, or county): Anne Arundel Co. (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ridgley Selby — ADDRESS: 502 4th St Laurel Md
24a. REC'D BY REGISTRAR DATE NOV 18 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684

CERTIFICATE OF DEATH

Reg. Dist. No. 12719

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.
d. STREET ADDRESS 1509 Gallatin St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47x-3

3. NAME OF DECEASED (Type or print) First Mary Middle Frances Lost Gibson

4. DATE OF DEATH Month November Day 16 Year 19 60

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3/27/70
9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME William Hault
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
INFORMANT Mrs. Gordon Gibson Address 1509 Gallatin St. N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Debilitation

DUE TO (b) Anorexia

DUE TO (c) Senile Deterioration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 19 60 to Nov 16 19 60 that I last saw the deceased alive on Nov 15 19 60, and that death occurred at 11:00a M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert T. Thibadeau M.D.
ADDRESS (Street, city or town, state) 10609 Concord Street
DATE SIGNED Nov 16, 1960

PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) removal
22b. DATE THEREOF 11/17/60
22c. NAME OF CEMETERY OR CREMATORY Ingersoll Cemetery
22d. LOCATION (City, town, or county) (State) Ontario, Canada

23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.
ADDRESS 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE NOV 17 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12797

CERTIFICATE OF DEATH

12720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY

c. LENGTH OF STAY IN 1b: 7 DAYS

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAITHERSBURG

d. STREET ADDRESS: 414 E. DIAMOND AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GLADYS Middle: LUCY Last: GILLIAM

4. DATE OF DEATH Month: NOVEMBER Day: 18 Year: 19 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/15/1890

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHNSON K. LILLY

14. MOTHER'S MAIDEN NAME: ALLIE GORE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-07-8230

INFORMANT: HOSPITAL RECORDS Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Boeck's Sarcoid — INTERVAL BETWEEN ONSET AND DEATH: Months

DUE TO (b) Pulmonary Tuberculosis, arrested. — Years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

002X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma, Hypertrophic Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1960 to Nov. 18, 1960 that I last saw the deceased alive on Nov. 18, 1960, and that death occurred at 7:55 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. — ADDRESS (Street, city or town, state): 105 Russell Ave. Gaithersburg, Md. — DATE SIGNED: 11-19-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-21-60

22c. NAME OF CEMETERY OR CREMATORY: Forest Oak

22d. LOCATION (City, town, or county) (State): Gaithersburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Francis L. Barb — ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR DATE NOV 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12798

CERTIFICATE OF DEATH

12721

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairland Md Silver Spring.
c. LENGTH OF STAY IN 1b: 3Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Nursing Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Silver Spring Md~~ Mt Rainier Md
d. STREET ADDRESS: 2901 Allison St. 1648-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Mary J Goodwine
4. DATE OF DEATH: Month 11 / Day 11 / Year 60 19

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 21
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ind.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moore
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
INFORMANT: Mrs William Scull — Address: 2901 Allison St, Mt Rainier Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DIS. — INTERVAL BETWEEN ONSET AND DEATH: 4 YEARS
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from NOV. 1956, to NOV. 11 1960, that I last saw the deceased alive on NOV 11 1960, and that death occurred at 12:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: P. L. Tabb M.D. — M.D. — ADDRESS (Street, city or town, state): 13000 GA. AVE - S.S. 170. — DATE SIGNED: 11/11/60
PHYSICIAN'S NAME (Type): S.L. TABB, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/14/60
22c. NAME OF CEMETERY OR CREMATORY: Tallulah Louisiana
22d. LOCATION (City, town, or county) (State): Louisiana

23. FUNERAL DIRECTOR'S SIGNATURE: W. K. Huntemann & Son — ADDRESS: Washington, D. 5732 Georgia Ave.
24c. REC'D BY REGISTRAR — DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Clothus S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12685 — 12722

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2316 Roar Rd.

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2316 Roar Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Max; Middle: Gordon; Last:

4. DATE OF DEATH: Month: Nov; Day: 20; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-25-13

9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parking lot operator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S. Africa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Gordon

14. MOTHER'S MAIDEN NAME: Molly Kline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joe Gordon (brother) Address: 1619 Noyes Dr Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous coronary attack

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 11-20-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: NOV. 21, 1960

22c. NAME OF CEMETERY OR CREMATORY: KING DAVID MEM-GARDEN

22d. LOCATION (City, town, or country): FALLS CHURCH (State): VA.

23. FUNERAL DIRECTOR: BERNARD DANZANSKY & SONS

ADDRESS: 3501-14th St. N.W.

24a. REC'D BY REGISTRAR DATE NOV 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12686 12723

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON-SILVER SPRING NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON
d. STREET ADDRESS 3219 DECATUR STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First DAVID Middle BRAINARD Last GOTTWALS
4. DATE OF DEATH Month NOV. Day 21 Year 19 60
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 8/9/58
9. AGE (In years last birthday) 102 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER - Self-employed
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) HANOVER, CANADA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ABRAHAM Z. GOTTWALS
14. MOTHER'S MAIDEN NAME MARY WAGNEST ~~unknown~~
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) Spanish American
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Esther G. Crandall, 2500 Upton St., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH 30 hrs
DUE TO (b) Thrombosis of anterior descending branch
DUE TO (c)
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-14 19 60 to 11-21 19 60 that (I) (we) last saw the deceased alive on 11-17 1960, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11-21-60
22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 11/25/60
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY
23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jska WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12799

CERTIFICATE OF DEATH

12724

Item 2 FilmG275 11-28-60 et

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~FAIRLAND~~ Olney
d. STREET ADDRESS RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First PATRICIA Middle S. Last GOW
4. DATE OF DEATH Month NOV. Day 15 Year 1960
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 2/3/86
9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Stirling
14. MOTHER'S MAIDEN NAME Elizabeth Rae
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. Harry P. Dodge, Address Route 1, Olney, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Parkinsonism — INTERVAL BETWEEN ONSET AND DEATH 10 yrs
DUE TO (b)
DUE TO (c)
350X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1958 19__ to 11/15 1960, that (I) (we) last saw the deceased alive on 11/15 1960, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE C. H. Wagner M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/16/60
22c. PHYSICIAN'S NAME (Type) C. H. Wagner
22d. ADDRESS Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
23b. DATE THEREOF 11/18/60
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY
23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Fiska WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 22 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12800 **CERTIFICATE OF DEATH** 12725

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [redacted]ed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Prince William
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gainesville
d. STREET ADDRESS: RFD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert; Middle: Boyce; Last: GOWAN
4. DATE OF DEATH: Month: November; Day: 14; Year: 1960
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-3-94
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): So. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christopher GOWAN
14. MOTHER'S MAIDEN NAME: Frances EARNEST
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1917 to 1945
16. SOCIAL SECURITY NO.: 215-12-3694
17. INFORMANT: (W) Mrs. Laura Gowan, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
(b) Carcinoma Kidney — 1 yr.
DUE TO
(c)

180X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~[illegible]~~) attended the deceased from Oct. 20, 1960, to Nov. 14, 1960, that (I) (~~[illegible]~~) last saw the deceased alive on Nov. 14, 1960, and that death occurred at 12 P M, from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Akers M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-14-60
22c. PHYSICIAN'S NAME (Type): R. E. AKERS, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-17-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W.W.Chambers, 3072 M St., NW, Washington, D. C.
25a. REC'D BY REGISTRAR — DATE: NOV 16 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

12687

12726

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Althea Woodland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 18501 Garland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred Middle: Lost: Graf
4. DATE OF DEATH: Month: 11 Day: 24 Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-30-83
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dr of Broadcasting
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: August Graf
14. MOTHER'S MAIDEN NAME: Henrietta Memmert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH: 5 Mos.
DUE TO
(b) Cerebral Hemorrhage — 5 Mos.
DUE TO
(c) Hypertension & Arteriosclerosis — ? years

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960, to Nov. 24 1960 that (I) (we) last saw the deceased alive on Nov 23 1960, and that death occurred at 9 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Robert A Hare M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-24-60
22c. PHYSICIAN'S NAME (Type): Dr. Robt. A. Hare
22d. ADDRESS: 809 Davis Ave., Takoma Pk, Md.

23a. BURIAL CREMATION REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 25 Nov. 1960
23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Rinaldi Funeral Home ADDRESS: 816 H St. N.E. DCV
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12801

CERTIFICATE OF DEATH

12727

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 150 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Milton
d. STREET ADDRESS: 1181½ Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

8 5X-3

3. NAME OF DECEASED (Type or print): First Barbara, Middle Ann, Last Green
4. DATE OF DEATH: Month November, Day 2, Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1941
9. AGE (In years last birthday): 19 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Melvin Burns
14. MOTHER'S MAIDEN NAME: Thelma Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Hemoperitoneum — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Choriocarcinoma with metastasis to brain, lungs & peritoneal cavity — 9 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 5, 1960, to November 2, 1960, that (I) (we) last saw the deceased alive on November 2, 1960, and that death occurred at 9:10 AM from the causes and on the date stated above.

22a. SIGNATURE: Leo Stolbach M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11/2/60
22c. PHYSICIAN'S NAME (Type): Leo L. Stolbach, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/3/60
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Martin, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co — ADDRESS: 1400 Chapin St NW
25a. REC'D BY REGISTRAR: DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12802 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12728

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda 14
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8604 Brickyard Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Bethesda 14 Potomac
d. STREET ADDRESS: 8604 Brickyard Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robin Middle: Lee Last: Griffith
4. DATE OF DEATH: Month: Nov Day: 4 Year: 1960
5. SEX: male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-4-60
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 2 Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.C.
13. FATHER'S NAME: Robert Griffith
14. MOTHER'S MAIDEN NAME: Betty Bowser
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or date of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Betty Griffith (Mother) Address: Stu 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): upper Respiratory Infection
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

475X

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-4-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/7/60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or country) (State): Suitland, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey, ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2074282XV4

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12803 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12729

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1305 U Street, S.E. Apt. 103
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

47X-3

3. NAME OF DECEASED (Type or print): First: Lily — Middle: Staples — Last: HAESLOOP
4. DATE OF DEATH: Month: November — Day: 2 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 1-1-89
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ebert STAPLES
14. MOTHER'S MAIDEN NAME: Mamie LAWLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage, intracerebral, spontaneous, left (Massive)
331X
DUE TO
(b) Atheresclerosis, generalized
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found unconscious on floor at home, apparently fallen preparing for bed.
20c. TIME OF INJURY: Hour a.m. Appr. 1xx — Month, Day, Year: 11-2 1960
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Washington, D.C. — (County): — (State):

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. BROSCHART, M.D.
Address (Street, city, town, or county): Gaithersburg, Md.
DATE SIGNED: 11-3-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-7-60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country): Arlington — (State): Virginia

23. FUNERAL DIRECTOR: Lee Funeral Home, 4th & Mass, Ave.NW, WashDC — ADDRESS:
24a. REC'D BY REGISTRAR: DATE NOV 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12804

CERTIFICATE OF DEATH

Reg. Dist. No. 12730

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Poolesville, Md
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willard Rd, Poolesville, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA Middle NAOMI Last HALL

4. DATE OF DEATH: Month November Day 16 Year 1960

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: January 1, 1895

9. AGE (In years lost birthday): 65 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Busey

14. MOTHER'S MAIDEN NAME: Idella Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Miss Bertha Hall — Address: Poolesville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
(b) metastatic carcinoma — 2 months
DUE TO
(c) Carcinoma of the liver — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

156.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to Nov. 16, 1960, that I last saw the deceased alive on Nov 16, 1960, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Lawrence M.D. — ADDRESS (Street, city or town, state): Damascus — DATE SIGNED: 11/16/60

PHYSICIAN'S NAME (Type): P. O. Box D, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b.** DATE THEREOF: 11/19/60 — **22c.** NAME OF CEMETERY OR CREMATORY: Warren Chapel — **22d.** LOCATION (City, town, or county) (State): Martinsburg, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunder — ADDRESS: Rockville, Md

24a. REC'D BY REGISTRAR — DATE NOV 22 '60

24b. REGISTRAR'S SIGNATURE: Cinthia S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

TO DEPU[illegible]EDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execu[illegible] the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fune[illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,

VS. A15ME
SW 7/59

FOR ST[illegible]
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1280 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12731

ATE DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Michigan
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Inkster
d. STREET ADDRESS: 28433 Oakwood Avenue 59X-3
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Dewitt; Middle: Clinton; Last: HAMEL

4. DATE OF DEATH: Month: November; Day: 8; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 11-20-26

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: [illegible]ry J. HAMEL

14. MOTHER'S MAIDEN NAME: Marie MEADE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1945 to DOD

16. SOCIAL SECURITY NO.: 369-22-3408

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	Transection of spinal cord at C3-4 region	5 days
DUE TO (b)	Comminuted fracture of cervical vertebrae	5 days
DUE TO (c)	Automobile accident	5 days

823X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which left road and overturned attempting to avoid headon collision.

20c. TIME OF INJURY: Hour 11:50 a.m. — Month, Day, Year: 11-3 19 60

20d. INJURY OCCURRED: While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street-Rt.222

20f. (City or town): Aiken — (County): Cecil — (State): Maryland

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 11-9-60

EXAMINER'S NAME (Type): Frank J. BROSCHART, M. D.

Address (Street, city, town, or county): Gaithersburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment

22b. DATE THEREOF: 11-10-60

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or country): Detroit — (State): Michigan

23. FUNERAL DIRECTOR: W.W.Chambers — ADDRESS: 1400 Chapin St., NW, WashDC

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: [illegible]

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12806

CERTIFICATE OF DEATH

12732

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Cherry Chase
d. STREET ADDRESS: 7104-46 Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: R.; Last: Hargett

4. DATE OF DEATH: Month: Nov.; Day: 2; Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/24/03
9. AGE (In years lost birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Investigator
10b. KIND OF BUSINESS OR INDUSTRY: Lawyer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. Hargett
14. MOTHER'S MAIDEN NAME: Clara Richter.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 578-05-4454
17. INFORMANT: Roland H. Hargett — Address: 6011-Wa Hemp Beth. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Posterior Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I ~~certify that~~ (I) (this hospital) attended the deceased from 10/28, 1960 to 11/2, 1960 that (I) (we) last saw the deceased alive on 11/2, 1960 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul D. Cantor M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/2/60
22c. PHYSICIAN'S NAME (Type): Paul D. Cantor
22d. ADDRESS: 4709 Montgomery Lane - Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/5/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 4 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12716 12753

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md.
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium/Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Silver Spring, Maryland
d. STREET ADDRESS: 7W Notley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Kenneth Middle: Eugene Last: Harris
4. DATE OF DEATH: Month: November Day: 6 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 14, 1894
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR OR UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Retired) Controller - U.S. Govt
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. States
13. FATHER'S NAME: Kenneth W Harris - - -
14. MOTHER'S MAIDEN NAME: Hettie Honeycutt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I Army
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Kenneth Harris Address: (Same address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tracheal Obstruction — Several days
DUE TO
(b) Malignant Tumor of lung — 1 yr.
DUE TO
(c)

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/7 1960, to 11/6 1960, that (I) (we) last saw the deceased alive on 11/6 1960, and that death occurred at 6:25 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Raymond O. West M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Raymond O. West
22d. ADDRESS: 7600 Carroll Avenue, Takoma Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/9/60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem. - Arlington, Virginia
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Glover ADDRESS: 2901-14th St. N.W. DC
25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12807

CERTIFICATE OF DEATH

Reg. Dist. No. 12734

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Mt. Airy
c. LENGTH OF STAY IN 1b: 2 wks

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Bethesda

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brown Nursing Home

d. STREET ADDRESS: 5714 Kingswood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle A. Last HARRISON

4. DATE OF DEATH: Month NOV. Day 11, Year 19 60

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-27-1884
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer --retired
10b. KIND OF BUSINESS OR INDUSTRY: owner
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Reuben Harrison
14. MOTHER'S MAIDEN NAME: Christina Gosnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 219-14-7628
17. INFORMANT: T.Woodrow Harrison, R.D 7 Frederick,Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(b) Coronary occlusion — Sudden
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: C M Van Poole M.D. ADDRESS (Street, city or town, state): Mt Airy Md DATE SIGNED: 11-15-60

PHYSICIAN'S NAME (Type): C M Van Poole

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-14-1960
22c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel
22d. LOCATION (City, town, or county) (State): Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Md.
24a. REC'D BY REGISTRAR DATE: NOV 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12688

Reg. Dist. No. 12735

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9908 MARKHAM STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 SILVER SPRING
d. STREET ADDRESS: 9908 MARKHAM STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle C Last HENDERSON

4. DATE OF DEATH: Month NOV. Day 18 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8/4/98

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Personal Property Assessor

10b. KIND OF BUSINESS OR INDUSTRY: Mont. Co. Gov't.

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: US.A.

13. FATHER'S NAME: JAMES HENDERSON

14. MOTHER'S MAIDEN NAME: ROBERTA unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW # 1

16. SOCIAL SECURITY NO.: 218-26-5348

17. INFORMANT: Mrs. Mary W. Henderson, 9908 Markham St. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11/19/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11/22/60

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeska
WARNER E. HUMPHREY, INC. ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: NOV 28 60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12746

CERTIFICATE OF DEATH

12736

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4025 Glenridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 41
d. STREET ADDRESS: 4025 Glenrdige ~~xxxxx~~ Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: E.; Last: Hendry

4. DATE OF DEATH: Month: Nov.; Day: 10; Year: 19 60

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 14, 1891

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: 5; Days: 26
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Walter A. England

14. MOTHER'S MAIDEN NAME: Temple Hood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Walton Hendry-Husband-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular collapse — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
(b) myocardial infarction
DUE TO
(c) arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1 1960 to Nov 10 1960 that (I) (we) last saw the deceased alive on Nov. 8 1960, and that death occurred at 2 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilfred R. Ehrmantraut M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/10/60

22c. PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut, M.D.

22d. ADDRESS: 4890 Battery Lane, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/12/60

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town, or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 14 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Items 18&21 Film 280 2-6-61 ans

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12747 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12737

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 6 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3414 Dupont Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3414 Dupont Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Joseph Last Henehan
4. DATE OF DEATH: Month Nov Day 22 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-16-31
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): tree expert
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Henehan
14. MOTHER'S MAIDEN NAME: Anna Jerrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): Korean War
16. SOCIAL SECURITY NO.: 192-24-9437
17. INFORMANT: J. J. Henehan Address: Silver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, bilateral, severe
812 X
DUE TO (b) Pressure c. cerebellum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Fracture, old, orbital plate, left frontal bone

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto
20c. TIME OF INJURY Month, Day, Year: Hour 1100 a. m. 8-21 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Wheaton (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-23-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/28/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave., Rockville, Md.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Item 20 Film 275 11-29-60 ams

12738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12808

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
d. STREET ADDRESS: 5623 - Ogden Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Cooney — Last: Henry
4. DATE OF DEATH: Month: Nov. — Day: 10 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/25/80
9. AGE (In years lost birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Govt.
10b. KIND OF BUSINESS OR INDUSTRY: Navy Dept.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Brian Henry
14. MOTHER'S MAIDEN NAME: Hester Cooney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mary M. Beam — Address: 5623 Ogden Rd. Springfield, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EMBOLUS, PULMONARY — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS
902.7
DUE TO (b) FRACTURE, (L) HIP — 6 DAYS
DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED — 15 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped from chair to floor
20c. TIME OF INJURY: Hour a. m. p. m. 7:40 — Month, Day, Year: 11-2-1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Conv. Home
20f. (City or town): Kensington — (County): Montg — (State): Md.

21. I certify that (I) (this hospital) attended the deceased from June 1958 to Nov 10 1960 that (I) (we) last saw the deceased alive on 11-9 1960 and that death occurred at 7:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip R. James, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Philip R. James
22d. ADDRESS: Washington Clinic

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/12/60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: H. S. H. Hines Co. — ADDRESS: 2901-14th St. N.W.
25a. REC'D BY REGISTRAR: DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: C. Thos. L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d[illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fun[illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12803 12733

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7200 Seven Locks Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 58 Bethesda
d. STREET ADDRESS: 7200 Seven Locks Rd.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Reather Middle Mary Louise Last Herbert
4. DATE OF DEATH: Month 11 Day 28 Year 19 60

5. SEX: female
6. COLOR OR RACE: col.
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 11/18/1960
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 1 Days 10; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Junior Ellis
14. MOTHER'S MAIDEN NAME: Irene Bradley Herbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Upper Respiratory Infection
DUE TO (c)

475X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 11/28/60
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/30/60
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park
22d. LOCATION (City, town, or country) (State): Rockville Md.

23. FUNERAL DIRECTOR: Robert L. Sanders
ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE DEC 5 '60
24b. REGISTRAR'S SIGNATURE: Carolyn L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12810

CERTIFICATE OF DEATH

12740

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Bethesda
d. STREET ADDRESS: 9125-Aldershot Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry; Middle: K.; Last: Hermsdorf

4. DATE OF DEATH: Month: Nov.; Day: 4; Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/6/18
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): consultant for Govt
10b. KIND OF BUSINESS OR INDUSTRY: State Dept.
11. BIRTHPLACE (State or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kurt Hermsdorf
14. MOTHER'S MAIDEN NAME: Martha Maser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes. (If yes, give war or dates of service): Army-World War II
16. SOCIAL SECURITY NO.: 112-05-8102
17. INFORMANT: Johanna Hermsdorf-wife-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b) Pulmonary embolism — 6 hours
DUE TO (c) Sigmoid carcinoma with metastasis — unknown

153.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 1960 to NOV 4 1960 that (I) (we) last saw the deceased alive on NOV 4 1960, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas F. O'Connor M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/4/60
22c. PHYSICIAN'S NAME (Type): THOMAS F. O'CONNOR M.D.
22d. ADDRESS: 4861 BATTERY LANE BETHESDA 14, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/8/60
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12811

CERTIFICATE OF DEATH

Reg. Dist. No. 12741

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 86 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: Hunting Towers, Center Bldg., Apt. 703
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bevin; Middle: Raymond; Last: Hewitt
4. DATE OF DEATH: Month: November; Day: 27; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 11, 1936
9. AGE (In years lost birthday): 24 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mathematician
10b. KIND OF BUSINESS OR INDUSTRY: Analytic services
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph J. Hewitt
14. MOTHER'S MAIDEN NAME: Millie Massey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 248-50-9444
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 Years
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pancytopenia with Bone Marrow Failure, Hepatic Failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 2, 1960, to November 27, 1960 that I last saw the deceased alive on November 27, 1960, and that death occurred at 12:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jerome B. Block M.D.
PHYSICIAN'S NAME (Type): JEROME B. BLOCK, M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 11-28-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 12/4/60
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Marion, South Carolina
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

12812

12742

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2904 Garfield Terrace, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Allen; Middle:; Last: HOBBS

4. DATE OF DEATH: Month: November; Day: 23; Year: 1960

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-30-99
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alexander HOBBS
14. MOTHER'S MAIDEN NAME: Louise ALLEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1916 to 1953
16. SOCIAL SECURITY NO.:
17. INFORMANT: (W)Mrs. Fayette L. P. Hobbs, same as #2 above — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b) Arteriosclerotic heart disease — 8 yrs.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

430.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Nov. 12, 1960 to Nov. 23, 1960, that (I) (~~we~~) last saw the deceased alive on Nov. 23, 1960, and that death occurred at 12PM, from the causes and on the date stated above.

22a. SIGNATURE: F. H. O'Connell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-23-60
22c. PHYSICIAN'S NAME (Type): F. H. O'CONNELL, LCDR, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-28-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Jos. Gawler's & Sons
ADDRESS: 1756 Penn. Ave.NW, WashDC
25a. RECEIVED BY REGISTRAR: NOV 28 60
DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

12813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peach Tree Road.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson (Rural) 04
d. STREET ADDRESS: Peach Tree Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PERCIVAL Middle J. Last HONEMOND

4. DATE OF DEATH: Month Nov. Day 14, Year 19 60

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1875

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Josiah Honemond

14. MOTHER'S MAIDEN NAME: Sarah Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Sarah Honemond — Address: Peach Tree Rd., Dickerson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemmorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO
(b) Hypertensive Cerebral Vascular Disease — 6 years
DUE TO
(c)

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiac Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Nov, 1960, to 14 Nov, 1960, that I last saw the deceased alive on 14 November, 1960, and that death occurred at 4:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon M Smith M.D. — ADDRESS (Street, city or town, state): Barnesville, Md. — DATE SIGNED: 14 Nov 60

PHYSICIAN'S NAME (Type): Gordon M. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/18/60

22c. NAME OF CEMETERY OR CREMATORY: Jerusalem Baptist.,

22d. LOCATION (City, town, or county) (State): Poolesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE NOV 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 14, 22c & d, Film G274 11/18/60 iwk

Reg. Dist. No. 12744

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Off Sunshine - Brighton Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: (50) ½ NEWTON ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First AGNES Middle LOUISE Last HORNE
4. DATE OF DEATH: Month NOV. Day 5 Year 1960 19
5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/12/25
9. AGE (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pratical Nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): GEORGIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GENERAL LEE COOK
14. MOTHER'S MAIDEN NAME: -----Bradshaw
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination
DUE TO (b) Laceration of aorta
DUE TO (c) Bullet wound

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in woods

9 8 1 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown. Found dead in woods along side of Sunshine - Bright road.
20c. TIME OF INJURY: Hour ? a. m. p. m. Month, Day, Year unknown 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): unknown
20f. (City or town) nr Sunshine (County) Montg. (State) Mdd.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/6/60
EXAMINER'S NAME (Type): FRANK J. BROCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-15-60
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
22d. LOCATION (City, town, or county): Baltimore Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: R. M. Harton
ADDRESS: 1334 Jan. St. N.W.
24a. REC'D BY REGISTRAR DATE NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12815

CERTIFICATE OF DEATH

12745

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 Hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4303 Knowles Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bertha — Middle A. — Last Hughes

4. DATE OF DEATH: Month 11 — Day 18 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/29/78
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William Appleby
14. MOTHER'S MAIDEN NAME: Augusta Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Helen Prevsil Daughter — Address: Same as Above

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination — INTERVAL BETWEEN ONSET AND DEATH: Often
DUE TO
(b) Ruptured Aortic Aneurysm, Abdominal — Hours
DUE TO
(c) Arteriosclerosis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 6 1944 to Nov. 18 1960 that (I) (we) last saw the deceased alive on Nov. 18 1960 and that death occurred at 12:35 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Katharine A. Chapman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Katharine Chapman
22d. ADDRESS: 3924 Baltimore St. Kensington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/21/60
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
23d. LOCATION (City, town, or county) (State): Gaithersburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12689 12746

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2702 FENIMORE ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 2702 FENIMORE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSE Middle BOWLES Last HUGHES SR.

4. DATE OF DEATH: Month NOV. Day 6 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/31/08
9. AGE (In years lost birthday): 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Supervisor
10b. KIND OF BUSINESS OR INDUSTRY: American Citizens Insurance Co.
11. BIRTHPLACE (State or foreign country): Orange County, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM GEORGE HUGHES
14. MOTHER'S MAIDEN NAME: LAURA PAYNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-32-2171
17. INFORMANT: Mrs. Georgia A. Hughes, Address: 2702 Fenimore Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) Coronary Arteriosclerosis — 4 years
DUE TO (c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 3 1953 to Nov 1960 that (I) (we) last saw the deceased alive on Nov 1960 and that death occurred at 4:4 M, from the causes and on the date stated above.

22a. SIGNATURE: John J Curry M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JOHN J. CURRY
22d. ADDRESS: 10620 Georgia Ave. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/9/60
23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
23d. LOCATION (City, town or county) (State): MONTGOMERY COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zeske
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

Item 18 Film 278 1-10-61 ams

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12747

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1808 McAuliffe Dr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1808 McAuliffe Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Quentin — Middle: Edmund — Last: Hulse
4. DATE OF DEATH: Month: Nov — Day: 27 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-16-26
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): Fla
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles C. Hulse
14. MOTHER'S MAIDEN NAME: Ruth C. Altwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Richard E. Hulse — Address: 1806 McAuliffe Dr Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema - bilateral
322.0
DUE TO (b): Aspiration of gastric contents
DUE TO (c): Acute alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-28-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/30/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12816 **CERTIFICATE OF DEATH** 12748

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1200 44th Place SE WDC
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William; Middle: George; Last: HUNTLEY
4. DATE OF DEATH: Month: November; Day: 7; Year: 19 60
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-11-82
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USMC
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED/USMC
11. BIRTHPLACE (State or foreign country): Mt. Ash, Wales, England ~~Pennsylvania~~
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George HUNTLEY
14. MOTHER'S MAIDEN NAME: Anna JAMES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — If yes, 11-29-04 to 9-14-45 (dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: (S) William J.J.Huntley — Address: 1215 Chillum Manor Rd. Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 199.2
DUE TO (b)
DUE TO (c) Carcinoma, metastatic - primary unknown 4 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Oct. 21 19 60 to Nov. 7 19 60 that (☒ (we) last saw the deceased alive on Nov. 7 1960, and that death occurred at 10:40AM M, from the causes and on the date stated above.

22a. SIGNATURE: Russell Miller Jr MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-7-60
22c. PHYSICIAN'S NAME (Type): Russell MILLER, JR., LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-10-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Jill Lee Bass
ADDRESS: Lee Funeral Home 4th&Mass. Ave. NW, WDC
25a. REC'D BY REGISTRAR: DATE NOV/8 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12817 12749

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington,
d. STREET ADDRESS: 1734 Potomac Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: John — Middle: Lee Roy — Last: HUTCHESON
4. DATE OF DEATH: Month: November — Day: 22 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-26-89
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles L. HUTCHESON
14. MOTHER'S MAIDEN NAME: Jane DENNY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (S) Fred D. Hutcheson, YN3, USNR, Miramar, Calif. — Address: Naval Air Sta.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
DUE TO
(b) Arteriosclerotic heart disease — years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 5, 1960 to Nov. 22, 1960 that (I) (~~we~~) last saw the deceased alive on Nov. 22, 1960, and that death occurred at 1:50PM, from the causes and on the date stated above.

22a. SIGNATURE: J. E. Stitcher M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11-23-60
22c. PHYSICIAN'S NAME (Type): J. E. STITCHER, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-28-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: ~~XXXX~~ W.W.CHambers Co., 517 11th St.SE,WashDC
25a. REC'D BY REGISTRAR: DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12818 **CERTIFICATE OF DEATH** 12750

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patuxent River (Rural)
d. STREET ADDRESS: 757B MEMQ, Naval Air Station
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

18X-2

3. NAME OF DECEASED (Type or print): First: James — Middle: Allen — Last: JOHNSON

4. DATE OF DEATH: Month: November — Day: 11 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 29 October 1960

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months: — Days: 13
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NA

10b. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William B. JOHNSON

14. MOTHER'S MAIDEN NAME: Carolyn COOPER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NA

17. INFORMANT: William B. JOHNSON — Address: 757B MEMQ NAS Patuxent River, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BACTEREMIA UNKNOWN ETIOLOGY
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 11-7 19 60 to 11-11 19 60 that (X) (we) last saw the deceased alive on 11-11 19 60, and that death occurred at 4:40 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11 November 1960

22c. PHYSICIAN'S NAME (Type): R. V. RACK, LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-12-60

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

23d. LOCATION (City, town, or county) (State): Great Mills Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND **ADDRESS**: Robinson Funeral Home Leonardtown Md
Robinson's Funeral Home, Leonardtown, Md.

25a. REC'D BY REGISTRAR DATE: NOV 17 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

205135 5XV5

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12819 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12751

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4826 Del Ray Ave

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4826 Del Ray Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Katherine Last: Jones
4. DATE OF DEATH: Month: Nov Day: 2 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-27-60
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: 4 Days: 5 IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tenn
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joe Jones
14. MOTHER'S MAIDEN NAME: Edna Poore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joe Jones (father) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Upper Respiratory Infection
DUE TO (c)

475X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-2-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/4/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 4 '60
24b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Noos

9VVVVVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12752

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 8317 Tahoma Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lawrence; Middle: Christian; Last: Juel
4. DATE OF DEATH: Month: 11; Day: 3; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-13-05
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto. Serv. Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Hicks Chevrolet
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James P. Juel
14. MOTHER'S MAIDEN NAME: Mary? Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Edna C. Juel — Address: 8317 Tahoma Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration — 2½ hrs

DUE TO (b) Bullet wound thru skull

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

E976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound thru skull
20c. TIME OF INJURY: Hour 3:00 a.m. p.m.; Month, Day, Year 11-3 1960
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Silver Spring (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-3-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 8 1960
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter W. Deal Funeral Home 4812 Ga. Ave.
24a. REC'D BY REGISTRAR — DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur J. Hirsch

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12820

CERTIFICATE OF DEATH

Reg. Dist. No. 12753

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1209 M Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Vinnia — Middle: Dell — Last: Karnes
4. DATE OF DEATH: Month: November — Day: 26, — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 13, 1905
9. AGE (In years lost birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rooming house owner
10b. KIND OF BUSINESS OR INDUSTRY: Hostelry
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jasper N. Benson
14. MOTHER'S MAIDEN NAME: Mary E. Welcher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-48-4745
INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 Hours

DUE TO (b) Acute Cardiovascular Collapse — 11 Hours

DUE TO (c) ? Septicemia and Pulmonary Atelectasis Bilateral — 11 Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post-operative (4 days) total pelvic exenteration and construction of ileal loop bladder

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 2, 1960 to November 26, 1960 that I last saw the deceased alive on November 26, 1960, and that death occurred at 5:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George F. Miller, Jr. M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 11/26/60

PHYSICIAN'S NAME (Type): George F. Miller Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec 2, 1960
22c. NAME OF CEMETERY OR CREMATORY: —
22d. LOCATION (City, town, or county) (State): Alderson, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: 517-11th St. S.E. Wash, D.C.
24a. REC'D BY REGISTRAR: DATE NOV 29 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12690 Reg. Dist. No. 12754

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: Since 3/22/60
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wheaton Sanitarium 11901 Ga. Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Chevy Chase, Maryland
d. STREET ADDRESS: 4815 Essex Ave (Somerset)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Florence Middle Sullivan Last Karney
4. DATE OF DEATH: Month Nov. Day 15 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 21, 1873
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Detroit, Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Sulkivan
14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Edwin Stohlman, Sr. Address: 4815 Essex Ave Chevy Chase Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 8 months
420.0
DUE TO
(b) Generalized arteriosclerosis, severe — 6 yrs.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 16, 19 54, to Nov. 15, 19 60, that I last saw the deceased alive on November 13, 19 60, and that death occurred at 12:45 pm from the causes and on the date stated above.

ACTUAL SIGNATURE: George Dewey M.D. ADDRESS (Street, city or town, state): The Argonne Apts. DATE SIGNED: 9/15/60

PHYSICIAN'S NAME (Type): George Dewey, M.D. 1629 Columbia Rd., N.W., Washington 9 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-18-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Elliott Cemetery
22d. LOCATION (City, town, or county) (State): Detroit, MICHIGAN

23. FUNERAL DIRECTOR'S SIGNATURE: H. Don. DeVol ADDRESS: 2224 - Wis. Ave
24a. REC'D BY REGISTRAR DATE: NOV 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Trask

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12821

CERTIFICATE OF DEATH

12755

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ropine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 4703 Chase Avenue, Bethesda
d. STREET ADDRESS: 1 4703 Chase Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine; Middle: V; Last: Keim

4. DATE OF DEATH: Month: Nove.; Day: 26; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 19, 1868

9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months: 5; Days: 7
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress maker-ret

10b. KIND OF BUSINESS OR INDUSTRY: Sewing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles Keim

14. MOTHER'S MAIDEN NAME: Magdalene (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Peter Haley, Neice-same 2d
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	2 days.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertensive heart disease	2 mos.
DUE TO (c)	Arteriosclerosis	20 yrs

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile cachexia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 16, 1946 to Nov. 26, 1960, that (I) (~~we~~) last saw the deceased alive on Nov. 19, 1960, and that death occurred at 8 P. M, from the causes and on the date stated above.

22a. SIGNATURE: A J Connolly M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/26/60

22c. PHYSICIAN'S NAME (Type): A. J. CONNOLLY-M.D.
22d. ADDRESS: 1635 IRVINE ST. N.W. WASH 16, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/28/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Thane

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12718 **CERTIFICATE OF DEATH** 12756

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 53 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8403 SLIGO CREEK PARKWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, 17
d. STREET ADDRESS: 8403 SLIGO CREEK PARKWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: MARY Middle: ANN Last: KING
4. DATE OF DEATH: Month: NOVEMBER Day: 27 Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 11, 1878
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KING GEORGE Co, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: PATRICK H. PAYNE
14. MOTHER'S MAIDEN NAME: AGNES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HARRY W. KING Address: 8403 SLIGO ~~CREEK~~ CREEK PKWY.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Arteriosclerosis — ?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1947 to 27 Nov 1960, that (I) (we) last saw the deceased alive on 27 Nov 1960 and that death occurred at 11:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William D. Aud M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/27/60
22c. PHYSICIAN'S NAME (Type): WILLIAM D. AUD
22d. ADDRESS: 9006 COLESVILLE ROAD, SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/29/60
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL
23d. LOCATION (City, town, or county) (State): SUITLAND, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 CARROLL ST. N.W. D.C.
25a. REC'D BY REGISTRAR DATE: NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12719 **CERTIFICATE OF DEATH** 12757

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 mi 10 min - Takoma Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47X-3
d. STREET ADDRESS: 4611 13 St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

075

3. NAME OF DECEASED (Type or print): First: Mrs Lucy; Middle: Ada; Last: Kirk
4. DATE OF DEATH: Month: 11; Day: 10; Year: 1960

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-1-78
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Henry Houser
14. MOTHER'S MAIDEN NAME: Emma Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ✓
If yes, give war or dates of service:
16. SOCIAL SECURITY NO.: Not Known
17. INFORMANT: Clark — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Hypertension — unknown
DUE TO (c): Generalized arteriosclerosis — unknown

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of rt. breast
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 1-26- 1958 to Nov. 10, 1960, that (I) (~~we~~) last saw the deceased alive on Nov 10 1960, and that death occurred at 9:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/10/60
22c. PHYSICIAN'S NAME (Type): EINO MAGI, M.D.
22d. ADDRESS: 918 Univ. Blvd. E. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11/12/60
23c. NAME OF CEMETERY OR CREMATORY: Methodist Churchyard Cem. Potomac, Md.
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co.
ADDRESS: 2901 14 St N.W.
25a. REC'D BY REGISTRAR DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12738

CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4904 Cumberland Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SS Chevy Chase

d. STREET ADDRESS: 4904 Cumberland Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TATIANA Middle V Last KUSHNAREFF

4. DATE OF DEATH Month Nov. Day 9 Year 1960

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 2/6/1881

9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months 9 Days 3 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? STATELESS

13. FATHER'S NAME: Vassily (Unknown)

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

INFORMANT: Katherine Krynitsky-daughter-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

330X

DUE TO (b) Subarachnoid Hemorrhage — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arterio Sclerosis — 20 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Oster arthritis — severe —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 7 Nov, 1960, to 9 Nov, 1960 that I last saw the deceased alive on 8 Nov, 1960, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Ball M.D. ADDRESS (Street, city or town, state): 7936 Georgetown Rd. Bethesda 14 Md. DATE SIGNED: 9 Nov 60

PHYSICIAN'S NAME (Type): John G. Ball

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/12/60

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 14 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12822

Reg. Dist. No. 12759

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 229 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.

d. STREET ADDRESS: 1373 Downing Street, N.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47x-3

M

050

3. NAME OF DECEASED (Type or print): First: John — Middle: Daniel — Last: Lewis, Jr.

4. DATE OF DEATH: Month: November — Day: 27 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: December 3, 1955

9. AGE (In years lost birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: John D. Lewis, Sr.

14. MOTHER'S MAIDEN NAME: Helen Ware

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

204.3

DUE TO

(b) Osteomyelitis of Face — 2 months

DUE TO

(c) Acute Lymphatic Leukemia — 18 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 12, 1960 to November 27, 1960 that I last saw the deceased alive on November 27, 1960, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward E Morse M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 11/28/60

PHYSICIAN'S NAME (Type): Edward E. Morse, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: Dec. 3, 1960 — **22c. NAME OF CEMETERY OR CREMATORY**: Lincoln Memorial — **22d. LOCATION** (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Frazier's Funeral Home, 389 R.I. Ave. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: DEC 1 '60 — **24b. REGISTRAR'S SIGNATURE**: Gertrude B. Kynard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12823

CERTIFICATE OF DEATH

12760

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 20 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 300 CALVIN LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma A — Middle: — Last: Logan

4. DATE OF DEATH: Month: Nov. — Day: 7 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 7, 1874

9. AGE (In years lost birthday): 86 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Phila. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JOHN LOGAN

14. MOTHER'S MAIDEN NAME: MARGARET KENNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: NIECE. (MRS. MARTIN BURKE) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: 36 Hours
443X
DUE TO
(b) CHRONIC COR PULMONALE — 10 years
DUE TO
(c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE — 20 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 30, 1960, to November 7, 1960, that (I) (we) last saw the deceased alive on Nov. 6 1960, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Gordon S Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: NOV 9 1960

22c. PHYSICIAN'S NAME (Type): GORDON S. ROSENBERGER

22d. ADDRESS: 310 E. Montgomery Ave. Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/12/60

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City, town, or county) (State): Philadelphia, Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Tyson Wheeler Funeral Home, 1331 E. Montgomery Avenue Rockville, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 9 '60

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12720 12761

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2407 Spencer Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Franklin Middle: Samuel Last: Long
4. DATE OF DEATH: Month: November Day: 5 Year: 1960

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-21-76
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-patent examiner
10b. KIND OF BUSINESS OR INDUSTRY: Attorney
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: ~~XXXXXXXXXX~~ Ephraim Long
14. MOTHER'S MAIDEN NAME: Mary Kirkham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-34-6268
17. INFORMANT: Address: Mrs. Hazel Roth (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: several weeks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Leukemia — 1 year

204-4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7/13/1960, to 11/5/1960, that (I) (we) last saw the deceased alive on 11/4/1960, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Donald Nelson M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/5/60
22c. PHYSICIAN'S NAME (Type): Donald Nelson
22d. ADDRESS: 10620 Georgia Ave Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/8/60
23c. NAME OF CEMETERY OR CREMATORY: Wash. Nat. Mem. Park
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Clifford S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12721 Item 22d, Film G274 11/17/60 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12762

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK.
c. LENGTH OF STAY IN 1b: 11 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8007-Wilowood Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK.
d. STREET ADDRESS: 8007-Wilowood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OWEN Middle P. Last LONG
4. DATE OF DEATH: Month Nov. Day 4 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 14, 1898
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: ENGINEER
11. BIRTHPLACE (State or foreign country): IRELAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAMES LONG
14. MOTHER'S MAIDEN NAME: CATHERINE RILEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: SUSAN LONG — Address: 8007-Wilowood Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

151X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Carcinoma stomach primary — 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to Nov. 4, 1960, that I last saw the deceased alive on Nov. 3, 1960, and that death occurred at 1:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A W Smith M.D. — ADDRESS (Street, city or town, state): 13018 Georgia Ave. Wheaton, MD. — DATE SIGNED: 11/4/60

PHYSICIAN'S NAME (Type): A.W. SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-7-60
22c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
22d. LOCATION (City, town, or county) (State): Wheaton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 3831 Ga Ave NW
24a. REC'D BY REGISTRAR — DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824

CERTIFICATE OF DEATH

12763

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7801 Maple Ridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Bethesda
d. STREET ADDRESS: 7801 Maple Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ~~Emma~~ Emma; Middle H; Last Looker

4. DATE OF DEATH: Month November; Day 21; Year 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/28/1874

9. AGE (In years lost birthday): 86 yrs.
IF UNDER 1 YEAR: Months 2; Days 23
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John L. Houchen

14. MOTHER'S MAIDEN NAME: Amanda Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: R. B. Looker-husband-same 2d
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 27, 1960, to Nov 21, 1960, that I last saw the deceased alive on Nov 20, 1960, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Sharpe M.D. — ADDRESS (Street, city or town, state): 10511 Summit Ave., Kensington, Md. — DATE SIGNED: 11/21/60

PHYSICIAN'S NAME (Type): George Sharpe M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/23/60

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: NOV 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12722 12764

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington
b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47X-3
d. STREET ADDRESS: 6209 Nebraska Ave NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle R Last LOVELESS
4. DATE OF DEATH: Month 11 Day 4 Year 1960
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-18-1890
9. AGE (In years lost birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Warren Loveless
14. MOTHER'S MAIDEN NAME: Carrie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: yes Unknown
17. INFORMANT: Hosp. Record. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 12 hr.
DUE TO (b) Arterial atherosclerosis — 10+ yr.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1 1952 to Nov 5 1960 that (I) (~~we~~) last saw the deceased alive on Nov 4 1960 and that death occurred at 1:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE: A H Richwine M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 5, 60
22c. PHYSICIAN'S NAME (Type): A. H. Richwine
22d. ADDRESS: 5522 Western Ave, Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE THEREOF: 11-7-60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Prince George Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE: C.A. Pumphrey Funeral Homes. ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12691

CERTIFICATE OF DEATH

12765

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE -- b. COUNTY --

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring

c. LENGTH OF STAY IN 1b 18 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.

47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 Colesville Road Marile a Nursing Home

d. STREET ADDRESS 2227 Wisconsin Ave., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Louise Middle E. Last MacDonald

4. DATE OF DEATH Month Nov Day 9 Year 1960

5. SEX female

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH March 17, 1886

9. AGE (In years last birthday) 74 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Connecticut

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alfred Edwards

14. MOTHER'S MAIDEN NAME --- Barker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Lois Rupert - Address 2227 Wisconsin Ave., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac Distress — INTERVAL BETWEEN ONSET AND DEATH 30 hr
DUE TO
(b) Chronic cardiac Disease — 3 years
DUE TO
(c) Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Vascular accident

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct 27 1960 to Nov 9 1960 that (I) (we) last saw the deceased alive on Nov 8 1960 and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE John S. Rogers M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) John S. Rogers

22d. ADDRESS 1919 Lamont St. N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 11/12/60

23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - ADDRESS 2901 14th St., N.W. Washington 9, D.C.

25a. REC'D BY REGISTRAR DATE NOV 14 '60

25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12825 **CERTIFICATE OF DEATH** 12766

M

073

I

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 6 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 07 GAITHERSBURG
d. STREET ADDRESS: 1 416 EAST DIAMOND AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAINHART, Middle NELLIE, Last
4. DATE OF DEATH: Month NOVEMBER, Day 11, Year 19 60

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/15/~~1886~~ 1887
9. AGE (In years last birthday): 73 ~~72~~ yrs.
IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: RANDOLPH J. STUP
14. MOTHER'S MAIDEN NAME: MARY ELIZABETH FLYNN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: HOSPITAL RECORDS, Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 7 hours
331X
DUE TO
(b) DIABETES MELLITUS — 26 years
DUE TO
(c) ARTERIAL HYPERTENSION — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIVORCED SENILITY
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from JAN. 19 60 to NOV. 11 19 60 that (I) (we) last saw the deceased alive on NOV 11 19 60 and that death occurred at 7:15 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Gordon Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: NOV. 14, 1960
22c. PHYSICIAN'S NAME (Type): GORDON S. ROSENBERGER, M. D.
22d. ADDRESS: ROCKVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 14 1960
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City, town, or county) (State): Gaithersburg md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR — DATE: NOV 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

12826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12767

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 9 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash D.C.
d. STREET ADDRESS: 4545 Conn Ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47 X-3

090

3. NAME OF DECEASED (Type or print): First: Philip — Middle: G — Last: Mandell
4. DATE OF DEATH: Month: Nov — Day: 27 — Year: 1960
5. SEX: male
6. COLOR OR RACE: Jewish
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr 10 1882
9. AGE (In years lost birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Druggist
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Moses Mandell
14. MOTHER'S MAIDEN NAME: Bella Spiegel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sophie Mandell — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 Mon
DUE TO
(b) Uremia + Diabetes Mellitus — 2 MO
DUE TO
(c) B.P.H — 2 yrs

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

0

21. I **certify** that (I) (this hospital) attended the deceased from 7-Feb 1960 to 27 Nov 1960 that (I) (we) last saw the deceased alive on 27 Nov 1960 and that death occurred at 6 P M, from the causes and on the date stated above.

22a. SIGNATURE: John Bosley Ziegler — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov. 27, 1960
22c. PHYSICIAN'S NAME (Type): JOHN BOSLEY ZIEGLER
22d. ADDRESS: OLNEY MD

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 29, 1960
23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden
23d. LOCATION (City, town, or county) (State): Falls Church, Va.
24. FUNERAL DIRECTOR'S SIGNATURE: B. DANZANSKY & SONS — ADDRESS: WASH. D.C.
25a. REC'D BY REGISTRAR DATE NOV 30 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12827

CERTIFICATE OF DEATH

12768

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Bethesda, Maryland
d. STREET ADDRESS: 1 6305 Stoneham Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

05

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: Slater — Last: Manganaro

4. DATE OF DEATH: Month: November — Day: 12 — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 5-14-54
9. AGE (In years lost birthday): 6 yrs. — IF UNDER 1 YEAR: Months 5, Days 24 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Francis Ferdinand Manganaro
14. MOTHER'S MAIDEN NAME: Carol Anne Slater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Francis F. Manganaro (F) — Address: 6305 Stoneham Road, Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Vasomotor & respiratory collapse
DUE TO
(b): Infiltrative brain tumor
DUE TO
(c):

237X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 11-8, 19 60, to 11-12, 1960, that ☒ (we) last saw the deceased alive on 11-12, 19 60, and that death occurred at 510 AM from the causes and on the date stated above.

22a. SIGNATURE: C W Bramlett M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-12-60
22c. PHYSICIAN'S NAME (Type): C. W. BRAMLETT, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-15-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE NOV 16 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

R.C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12769

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6811 FAIRFAX Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

48

3. NAME OF DECEASED (Type or print): First: FARLE Middle: ROLLINS Last: MARDEN

4. DATE OF DEATH: Month: Nov. Day: 29 Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 25, 1901

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: Post OFFICE

11. BIRTHPLACE (State or foreign country): RYE, New Hampshire

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: JAMES MARDEN

14. MOTHER'S MAIDEN NAME: GRACE ROLLINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1920-22

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Velma L. Marden Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
DATE SIGNED: 11-29-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 12/2/60

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or county) (State): Ft. Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: A H Hines Co. ADDRESS: 2901 14st NW

24a. REC'D BY REGISTRAR DATE: DEC 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

M

099

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible]rector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12723 12770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: W.O.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash. San + Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 16532
d. STREET ADDRESS: 418 Lincoln Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Daisy; Middle: Elizabeth; Last: McCloskey
4. DATE OF DEATH: Month 11; Day 21; Year 1960
5. SEX: W
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 4-3-92
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housf.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Stark
14. MOTHER'S MAIDEN NAME: Lillian Lupold
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lula G. McCloskey — Address: Same as Deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-21-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 25, 1960
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince George County, Maryland
23. FUNERAL DIRECTOR: J. Arthur Walters, ADDRESS: 254 Carroll St. N.W. DC
24a. REC'D BY REGISTRAR: NOV 23 '60 DATE
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

12829

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12771

1. PLACE OF DEATH
a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Col.
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2226-Nicholson St. SE
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Marion; Middle: V.; Last: McDaniels
4. DATE OF DEATH: Month: Nov; Day: 4; Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/22/24
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Air Force
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Walter McDaniel
14. MOTHER'S MAIDEN NAME: Lewell Bridges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lewell Morris, Address: 2226-Nicholson St. S.E. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Spontaneous subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11/1/60
DUE TO
33 ox
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — INTERVAL: 11/4/60
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/1 1960 to 11/4 1960 that (I) (we) last saw the deceased alive on 11/4 1960, and that death occurred at 10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Clarence A. Gray Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/4/60
22c. PHYSICIAN'S NAME (Type): George A. Gray, Jr.
22d. ADDRESS: 4740 Chevy Chase DR. Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-7-60
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City, town, or county) (State): Bladensburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300-4th St. NE
25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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12739

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3805 Woodbine Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): S1 Chevy Chase
d. STREET ADDRESS: 3805 Woodbine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Louis; Middle: Kenneth; Last: McDorman
4. DATE OF DEATH: Month: November; Day: 24; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 17 1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): As Job
10b. KIND OF BUSINESS OR INDUSTRY: Manufact. Agent
11. BIRTHPLACE (State or foreign country): Somerset County, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: J. E. Kenneth McDorman
14. MOTHER'S MAIDEN NAME: Mary Schwartz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 578-01-8518
17. INFORMANT: wife, Address: 3805 Woodbine St. Ch. Ch. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO (b) Arteriosclerosis — years.
DUE TO (c) Cerebral Hemorrhage — 1958

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957, to Nov 24, 1960, that I last saw the deceased alive on October, 1960, and that death occurred at 10:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A Hare M.D. — ADDRESS (Street, city or town, state): 809 Davis ave. Takoma Pk. Md. — DATE SIGNED:
PHYSICIAN'S NAME (Type): Robert A. HARE — 809 Davis Ave. Tk. Pk. Md. — 11/24/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur, Transit
22b. DATE THEREOF: 11/27/60
22c. NAME OF CEMETERY OR CREMATORY: Peninsula Mem. Park
22d. LOCATION (City, town, or county) (State): Newport News, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

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12830

12773

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

073

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 16226 COLESVILLE ROAD, BOX 134
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: OSCAR — Middle: JAMES — Last: MCKINNEY

4. DATE OF DEATH: Month: NOVEMBER — Day: 4, — Year: 19 60

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JUNE 6, 1881

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): TENNESSEE

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JAMES MCKINNEY

14. MOTHER'S MAIDEN NAME: HATTIE ATLINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HOSPITAL RECORDS, OLNEY, MARYLAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(b) Chronic myocarditis — 422.2 — 7 yrs
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/4, 19 60, to 11/4, 19 60, that (I) (we) last saw the deceased alive on Nov 4, 1960, and that death occurred at 10:50 A.M./P.M. from the causes and on the date stated above.

22a. SIGNATURE: C. H. Ligon — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — **22b. DATE SIGNED**

22c. PHYSICIAN'S NAME (Type): C. H. LIGON, M. D.

22d. ADDRESS: SANDY SPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: 11-11-60-1960

23c. NAME OF CEMETERY OR CREMATORY: Natl' Harmony Mem.

23d. LOCATION (City, town, or county) (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Frazier's Funeral Home, Inc. 389 R.I. Ave. N.W.

25a. REC'D BY REGISTRAR DATE NOV 7 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12724 12774

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1427 Highland Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: Purdy; Last: McLeod
4. DATE OF DEATH: Month: 11; Day: 19; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/30/1898
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent of Bldgs.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. D.C. City Post Office
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? Amer
13. FATHER'S NAME: E. Patton McLeod
14. MOTHER'S MAIDEN NAME: Susan Gaillard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: 217-34-1799
17. INFORMANT: Wife — Address: 1427 Highland Drive S Spo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Coronary Occlusion (thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocardial Infarction, Previous
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from — 1956 to Nov. 19 1960, that (I) (we) last saw the deceased alive on Nov. 15 1960, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Whikeels M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JAMES M. WHIKEELS
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/23/60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fitz
WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Anthony J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12831

12775

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 150 Darrington St., S. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X-3

051

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Gordon — Last: MICHAEL

4. DATE OF DEATH: Month: November — Day: 2 — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-1-60
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Gordon MICHAEL
14. MOTHER'S MAIDEN NAME: Shirley Mae O'CONNOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (F) Paul G. Michael, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Neonatal atelectasis, cause undetermined
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Patent ductus arteriosus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from Nov. 1 19 60 to Nov. 2 19 60, that (I) ~~[illegible]~~ last saw the deceased alive on Nov. 2 19 60 and that death occurred at 1:45PM M, from the causes and on the date stated above.

22a. SIGNATURE: Robert V. Rack M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-3-60
22c. PHYSICIAN'S NAME (Type): Robert V. RACK, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-4-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hanlon Funeral Home, 3831 Georgia Ave., N.W., WDC
25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

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12776

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2412 Evans Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell Middle: Douglas Last: Milner

4. DATE OF DEATH: Month: 11 Day: 6 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-9-1903

9. AGE (In years lost birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10b. KIND OF BUSINESS OR INDUSTRY: Thomas Cope - Sun Travel Agency

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Clarence O. Milner

14. MOTHER'S MAIDEN NAME: Martha Jensen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 579-42-1361

17. INFORMANT: Washington Sanitarium & Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarct involving left anterior — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO descending coronary artery
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Massive myocardial fibrosis involving left — Since 1952
DUE TO antero-lateral myocardium
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary Thrombosis (old) 1952

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 20 1952 to Nov 6, 1960, that (I) (we) last saw the deceased alive on Nov 5 1960 and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George L. Ball M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Nov 6 1960

22c. PHYSICIAN'S NAME (Type): George L. Ball

22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11/9/60

23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zirka — WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.

25a. REC'D BY REGISTRAR DATE NOV 14 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

12748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12777

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 yr. 8 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 50
d. STREET ADDRESS: 4618 Highland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olivia; Middle: P.; Last: Mitchell

4. DATE OF DEATH: Month: 11; Day: 1; Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/1/1867

9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George A. Perrie

14. MOTHER'S MAIDEN NAME: Helen Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Thomas W. Pyle-son in law-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerosis generalized — 10 years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1953 19__, to 11-1 1960, that (I) (we) last saw the deceased alive on 10-29 1960, and that death occurred at 11:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/1/60

22c. PHYSICIAN'S NAME (Type): Alfred S. Norton

22d. ADDRESS: 4711 Highland Ave. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/4/60

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: NOV 3 '60

25b. REGISTRAR'S SIGNATURE: Carlton S. Knauf

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12726 Reg. Dist. No. 12778

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, 34
d. STREET ADDRESS: 4001 Weller Road, 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Monkiewicz

4. DATE OF DEATH: Month November, Day 13, Year 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: November 13, '60
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours 15 Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chester John Monkiewicz
14. MOTHER'S MAIDEN NAME: Jean Marie Smink

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: mother Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL ANOXIA - APNEA — INTERVAL BETWEEN ONSET AND DEATH: 16 HOURS
DUE TO
(b) SHOULDER PRESENTATION (TWIN) — 16 HOURS.
DUE TO
(c) IN UTERO, PLACENTAL SEPARATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from NOV. 13, 1960, to NOV. 13, 1960, that I last saw the deceased alive on NOV. 13, 1960, and that death accurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L. Krichmar M.D. — ADDRESS (Street, city or town, state): 7733 ALASKA AVE NW — DATE SIGNED: NOV 16 1960
PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR M.D — WASHINGTON 12 D.C

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 11-14-60
22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital
22d. LOCATION (City, town, or county) (State): Takoma Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M.D. Washington San & Hosp.
ADDRESS:
24a. REC'D BY REGISTRAR DATE NOV 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

2175343XV5

1 12 M 050 I 2 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12832

CERTIFICATE OF DEATH

12779

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2325 42nd Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Marjorie — Middle: Maude — Last: Morey
4. DATE OF DEATH: Month: November — Day: 19 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 28 1909
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Milliner ~~Milliner~~
10b. KIND OF BUSINESS OR INDUSTRY: Store
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert John Willoughby
14. MOTHER'S MAIDEN NAME: Fanny M. Statton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 389-18-2484
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
754.5
DUE TO
(b) Staphlococcal Mediastinitis and Pericarditis — Days
DUE TO
(c) Status Post-Operative ASD Repair — 11 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Atrial Septal Defect Post- Operative

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 19, 1960, to November 19, 1960, that I last saw the deceased alive on November 19, 1960, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. C. Brockenbrough, M.D. — M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 11/19/60
PHYSICIAN'S NAME (Type): E. C. Brockenbrough M.D.

22a. ~~BURIAL~~, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 11/21/60
22c. NAME OF CEMETERY OR CREMATORY: Beechwood Cemetery
22d. LOCATION (City, town, or county) (State): Ottawa, Canada

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., — ADDRESS: 2901 14th St. N.W., Wash.D.C.
24a. REC'D BY REGISTRAR — DATE: NOV 21 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be ret[illegible] by the hospital or attending physician.
TO FUNERAL [illegible]ECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible]e funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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12833

12780

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

M

074

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1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Va
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charles Town
d. STREET ADDRESS: Box 410 - R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

65X-3

3. NAME OF DECEASED (Type or print): First: Frances — Middle: — Last: Moulton
4. DATE OF DEATH: Month: Nov. — Day: 20 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/14/79
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lemon Parker Rawlings
14. MOTHER'S MAIDEN NAME: Julia Monnier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dr. Barbara Moulton-daughter — Address: 5123 Bradley Blvd. Beth, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b) Interstitial nephrosclerosis — 5 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

446X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of the pancreas with liver metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Oct. 20, 1960 to Nov. 20, 1960 that (I) ~~(we)~~ last saw the deceased alive on Nov 20 1960 and that death occurred at 7:15 p. M. from the causes and on the date stated above.

22a. SIGNATURE: Senich T. Kimble, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/20/60
22c. PHYSICIAN'S NAME (Type): Senich T. Kimble
22d. ADDRESS: 929 Pershing Dr., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/23/60
23c. NAME OF CEMETERY OR CREMATORY: Edgehill Cemetery
23d. LOCATION (City, town, or county) (State): Charles Town, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE NOV 23 '60
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

12834

12781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1533 Massachusetts Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X -3

3. NAME OF DECEASED (Type or print): First: Anna; Middle: Frances; Last: MURRAY

4. DATE OF DEATH: Month: November; Day: 18; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-22-91

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - -

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William BELL

14. MOTHER'S MAIDEN NAME: Alice BARRICK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 577-12-2505

17. INFORMANT: (H) Wm. R. Murray, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Rheumatic Heart Disease — 4 days
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

416

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Nov. 15 1960 4:45AM to Nov. 18, 1960, that ☒ (we) last saw the deceased alive on Nov. 18 1960, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: R. Muth M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-18-60

22c. PHYSICIAN'S NAME (Type): R. MUTH, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-22-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.
ADDRESS: W.W.Chambers Co., 517 11th Street,S.E, WashDC

25a. REC'D BY REGISTRAR DATE: NOV 22 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12835

CERTIFICATE OF DEATH

12782

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 14 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1524 F Street, N.E. - Apt. 105
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 X -3

3. NAME OF DECEASED (Type or print): First: Ella; Middle: Lee; Last: MUSE

4. DATE OF DEATH: Month: November; Day: 22; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4-1-05

9. AGE (In years lost birthday): 55 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John BROOKS

14. MOTHER'S MAIDEN NAME: Estelle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: (S) Morris E. Christian, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Arteriosclerotic & hypertensive heart disease — 20 yrs.
DUE TO
(c)

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Nov. 21, 19 60, to Nov. 22, 19 60, that (X) (we) last saw the deceased alive on Nov. 22, 19 60, and that death occurred at 12:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: R. G. Muth M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-22-60

22c. PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-29-60

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cemetery

23d. LOCATION (City, town, or county) (State): Suitland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J.T. Rhines
ADDRESS: J.T.Rhines Funeral Home, 3015 12th St.,NE WashDC

25a. REC'D BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

CERTIFICATE OF DEATH

12783

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Clarksburg----Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Wesley — Last: Nichols

4. DATE OF DEATH: Month: Nov — Day: 6 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 3-1882
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lee Andrew F.Nichols
14. MOTHER'S MAIDEN NAME: Margaret Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Address: Mrs Gladys Nicholson, Poolesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Rt hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b) Hypertensive - Arteriosclerotic Cardiovascular Disease — 3 years
DUE TO
(c)

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Oct., 1960, to 6 Nov., 1960, that I last saw the deceased alive on 5 November, 1960, and that death occurred at 7 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon M Smith — M.D. — ADDRESS (Street, city or town, state): Barnesville, Md. — DATE SIGNED: 6 Nov 60

PHYSICIAN'S NAME (Type): Gordon M.Smith

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov.8.1960
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): Hyattstown, Md

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton — ADDRESS: Barnesville, Md
24a. REC'D BY REGISTRAR DATE: NOV 9 '60
24b. REGISTRAR'S SIGNATURE: Chas. L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12837 **CERTIFICATE OF DEATH** 12784

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring
d. STREET ADDRESS: 704 McNeill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: Mae; Last: Niple
4. DATE OF DEATH: Month: 11; Day: 17; Year: 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ~~xx/xx/xx~~ 7/3/81
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Levi Gill
14. MOTHER'S MAIDEN NAME: Augusta Wilson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Elsie Burton (daughter) same as above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs
DUE TO
(b) Arteriosclerosis
DUE TO
(c)

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 to 17 Nov 1960 that (I) (we) last saw the deceased alive on 17 Nov 1960 and that death occurred at 8:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William D. Aud M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/17/60
22c. PHYSICIAN'S NAME (Type): WILLIAM D. AUD
22d. ADDRESS: 9006 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/21/60
23c. NAME OF CEMETERY OR CREMATORY: BURTONSVILLE UNION CEMETERY
23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeller
ADDRESS: WARNER E. PUMPHREY, INC. SILVER SPRING, MD.
25a. REC'D BY REGISTRAR: DATE NOV 23 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

12838

12785

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2700 Wisconsin Avenue, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle Jane R Last Norris

4. DATE OF DEATH: Month Nov. Day 17 Year 1960

5. SEX: Fem.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/19/74
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months 11 Days 28
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Gov't Employee
10b. KIND OF BUSINESS OR INDUSTRY: Claims Dept.
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stitt
14. MOTHER'S MAIDEN NAME: Maria Hanger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter, Mrs. George Horning, Jr. Address: Chevy Chase, Md. 5325 Kenwood Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO (b) Myocardial infarction — 5 wks.
DUE TO (c) Coronary arteriosclerotic heart disease ? 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/9 1960 to 11/17/60 19 that (I) (we) last saw the deceased alive on 11/16 1960 and that death occurred at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard J. Walsh M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/17/60
22c. PHYSICIAN'S NAME (Type): Bernard J. Walsh
22d. ADDRESS: 1800 Eye St. N.W. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/19/60
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 21 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12839

CERTIFICATE OF DEATH

12786
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: 1401 Diamond Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean H. Middle: Last: Oden
4. DATE OF DEATH: Month: 11 Day: 19 Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/15/32
9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kirby Smith
14. MOTHER'S MAIDEN NAME: Audrey Getz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Porter F Oden-Item# 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 6 WEEKS
DUE TO
(b) CARCINOMA OF BREAST — 5 MOS.
DUE TO
(c)

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCT. 1, 1960 to NOV. 19, 1960 that I last saw the deceased alive on NOV. 19, 1960, and that death occurred at 6:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Tuohy M.D. ADDRESS (Street, city or town, state): 7720 WISC. AVE, BETHESDA, MD. DATE SIGNED: 11/19/60

PHYSICIAN'S NAME (Type): John H. Tuohy 7720 Wis. Ave., Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/22/60
22c. NAME OF CEMETERY OR CREMATORY: StlLukes Church Cem.
22d. LOCATION (City, town, or county) (State): Redland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler — ADDRESS: 1331 E. Montgomery Ave. Rockville, Md.
24a. REC'D BY REGISTRAR DATE: NOV 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12727

CERTIFICATE OF DEATH

12787

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Montegomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 404 Torrington Place,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First — Middle — Last: Oehl
4. DATE OF DEATH: Month: November — Day: 5 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-5-60
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 10 — Min.: 30

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Richard A. Oehl
14. MOTHER'S MAIDEN NAME: Geraldine Lee Kushon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: father — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyaline membrane Disease of Lungs
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 1/2 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 November 1960 to _____ 19____, that I last saw the deceased alive on 5 November 1960, and that death accurred at 10:45 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell B. Arnold M.D. — ADDRESS (Street, city or town, state): 8801 Colesville Road, — DATE SIGNED: 11/5/60

PHYSICIAN'S NAME (Type): Russell B. Arnold — Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 11-6-60
22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium & Hospital
22d. LOCATION (City, town, or county) (State): Takoma Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M.D. — ADDRESS: Washington
24a. REC'D BY REGISTRAR — DATE: NOV 8 1960
24b. REGISTRAR'S SIGNATURE: [illegible]

2075 301 XU4 San & Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12840 12788

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McArthur
d. STREET ADDRESS: - - - - - - - - 72X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Vance — Last: OGAN

4. DATE OF DEATH: Month: November — Day: 1 — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11-13-83
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph D. OGAN
14. MOTHER'S MAIDEN NAME: Nancy Jane HUGGINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1901-1939
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.
DUE TO
(b) CARCINOMA OF PROSTATE — 3 YEARS.
DUE TO
(c)

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROSIS, GENERALIZED

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 19 59 to Nov. 1, 19 60, that (I) (we) last saw the deceased alive on Nov. 1 19 60, and that death occurred at 4A M, from the causes and on the date stated above.

22a. SIGNATURE: W. L. DeBolt LTMC USN — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-1-60
22c. PHYSICIAN'S NAME (Type): W. L. DEBOLT, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 11-2-60
23c. NAME OF CEMETERY OR CREMATORY: Elk Cemetery
23d. LOCATION (City, town, or county) (State): McArthur Ohio

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons
ADDRESS: Jos. Gawler's & Sons, 1756 Penn. Ave., N.W., WashDC
25a. REC'D BY REGISTRAR: DATE NOV 3 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12841

CERTIFICATE OF DEATH

Reg. Dist. No. 12789

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RESMOR SANITARIUM

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (WASHINGTON DC) 47X-3
d. STREET ADDRESS: 4845 LOUGHBORO RD. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle DEPUE Last OGDEN

4. DATE OF DEATH: Month NOV. Day 4 Year 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 13, 1867
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID A. DEPUE
14. MOTHER'S MAIDEN NAME: DELIA ANN SLOCUM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: GEN. DAVID OGDEN — Address: 4845 LOUGHBORO RD NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteio-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(b) Senility — 12 yrs.
DUE TO
(c)
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1958, to Nov. 4, 1960, that I last saw the deceased alive on Oct. 30, 1960, and that death occurred at 3 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Geo. R. Huffman M.D. — ADDRESS (Street, city or town, state): 1912 - 19th St. N.W. DC — DATE SIGNED:

PHYSICIAN'S NAME (Type): George R. Huffman

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7 Nov. 1960
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): NEWARK NEW JERSEY

23. FUNERAL DIRECTOR'S SIGNATURE: RINALDI FUNERAL HOME INC — ADDRESS: 816 18th N.E. DC
24a. REC'D BY REGISTRAR DATE: NOV 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12842 **CERTIFICATE OF DEATH** 12750

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville,
d. STREET ADDRESS: 13114 Dumbarton Dr. Rockville Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Rebecca Middle: Iris Last: Oliver
4. DATE OF DEATH: Month: Nov. Day: 18 Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/11/55
9. AGE (In years last birthday): 5 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Simon Oliver
14. MOTHER'S MAIDEN NAME: Lola Hinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Father. Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforation trachea — 2 hrs.
DUE TO (b) Erosion tracheotomy tube
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

SDX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia, Cerebral palsy, Microcephally, epilepsy

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Oct 1957 to Nov 1960, that (I) (~~we~~) last saw the deceased alive on 11/18 1960, and that death occurred at 5 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Richard Auld M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Richard Auld
22d. ADDRESS: 800 Veirs Mill Rd. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/22/60
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town, or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Cristina S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1 # M 051 I 2 1

12843

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12791

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 74 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Calverton
d. STREET ADDRESS: - - - - - - - 83X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ray; Middle: Albert; Last: O'ROARK
4. DATE OF DEATH: Month: November; Day: 4; Year: 1960
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-10-01
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Daniel O'ROARK
14. MOTHER'S MAIDEN NAME: Margaret Jane STIDHAM
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI & II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Carcinoma of lung — 6 mos.
DUE TO (c)

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from August 22, 1960 to Nov. 4, 1960, that (I) ~~[illegible]~~ last saw the deceased alive on Nov. 3, 1960, and that death occurred at 6:05 AM, from the causes and on the date stated above.

22a. SIGNATURE: William P Baker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-4-60
22c. PHYSICIAN'S NAME (Type): William P. BAKER, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-8-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Va.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.
25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

12844

12792

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac(Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ropine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4214 Thornapple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSEPH — Middle: E — Last: O'TOOLE

4. DATE OF DEATH: Month: November — Day: 29 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 15, 1891

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months: 1 — Days: 14 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney-retired

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Patrick O'Toole

14. MOTHER'S MAIDEN NAME: Ellen Riarden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 577-10-6479

17. INFORMANT: Katherine H. O'Toole-wife-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) Cerebrovascular Accident and Pneumonia — 1 week
DUE TO
(c) Cerebroarteriosclerosis — 10 years

33 IX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Upper GI Bleeding

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 19 60, to Nov 28 19 60, that (I) (we) last saw the deceased alive on Nov 28 19 60, and that death occurred at 1:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W H Killay M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/29/60

22c. PHYSICIAN'S NAME (Type): W H Killay

22d. ADDRESS: 10222 Falls Rd Rockville

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/3/60

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: DEC 2 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12728 12793

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15
d. STREET ADDRESS: 304 Southwest Drive 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Cora Middle: (NMN) Last: Overby
4. DATE OF DEATH: Month: Nov. Day: 9 Year: 1960
5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 7-9-75
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Arnold
14. MOTHER'S MAIDEN NAME: Louise Snodgrass
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Son - Mr. Archer R. Overby - Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cerebral vascular accident
DUE TO
(b) Generalized arteriosclerosis
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3 3 1 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 1960, to Nov. 9 1960, that (I) (we) last saw the deceased alive on Nov. 9 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov. 9, 1960
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-10-60
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): VICKSBURG - Miss.
24. FUNERAL DIRECTOR'S SIGNATURE: HANLON FUNERAL HOME ADDRESS: 3831 GA. AVE.
25a. REC'D BY REGISTRAR DATE NOV 16 '60
25b. REGISTRAR'S SIGNATURE: Anthony J. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12845

CERTIFICATE OF DEATH

12794

Reg. Dist. No.

M

090

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington, D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47X-3
d. STREET ADDRESS: 5017 Loughboro Rd. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hubert — Middle: E — Last: Page
4. DATE OF DEATH: Month: Nov. — Day: 8 — Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 13 1868
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (State or foreign country): Whitewater, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Page, Joseph Hubert
14. MOTHER'S MAIDEN NAME: Page, Esterly Era
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. — (If yes, give war or dates of service): — — —
16. SOCIAL SECURITY NO.: —
INFORMANT: Esterly C. Page (Son) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic H.D. c age degenerations — INTERVAL BETWEEN ONSET AND DEATH: Four weeks
420.0
DUE TO (b): Advanced arteriosclerosis generalized — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I(a): many - Fall c fractured shoulder - renal failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall c fractured shoulder (minor contrib factor only)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 25, 1960, to Nov 9, 1960, that I last saw the deceased alive on Nov 6, 1960, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T Sullivan M.D. — ADDRESS (Street, city or town, state): 1800 - Eye St. N.W. Wash. 6, D.C. — DATE SIGNED:
PHYSICIAN'S NAME (Type): Richard T Sullivan M.D. — 1800 - Eye St. N.W. — 11/9/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 11-10-1960
22c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
22d. LOCATION (City, town, or county) (State): Whitewater, Wisc.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlik Sons Inc. — ADDRESS: 1756 Pa. Ave. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1
FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12795

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 10 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4303 Brookfield Dr

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4303 Brookfield Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alex, Middle John, Last Papanicolas
4. DATE OF DEATH: Month Nov, Day 9, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-8-1923
9. AGE (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Liquor
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Papanicolas
14. MOTHER'S MAIDEN NAME: Bessie Zonou
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give were or dates of service): WW 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Marie Papanicolas (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/14/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or country) (State): Arlington, Virginia
23. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: NOV 14 60 DATE
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

12846

12796

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 17 Film 6276 12-16-60 et

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 147 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Arlington
d. STREET ADDRESS: 4121 33rd Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Lassiter — Last: PARISEAU

4. DATE OF DEATH: Month: November — Day: 24 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-29-18

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert R. LASSITER

14. MOTHER'S MAIDEN NAME: Dearborn TREVETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: (H) CDR Jos A. R. Pariseau, USN, same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, breast with metastasis
DUE TO
(b)
DUE TO
(c)

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (X) (this hospital) attended the deceased from July 1 19 60 to Nov. 24 19 60 that (X) (we) last saw the deceased alive on Nov. 24 1960, and that death occurred at 9:15PM M. from the causes and on the date stated above.

22a. SIGNATURE: D. L. Kelley M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-25-60

22c. PHYSICIAN'S NAME (Type): D. L. KELLEY, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-29-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: C. M. Grace — ADDRESS: Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.

25a. REC'D BY REGISTRAR — DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12847

CERTIFICATE OF DEATH

12797

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colesville
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 14511 Colesville RD

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook Md 1604.2
d. STREET ADDRESS: 9900 Santa Cruz St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Loring — Middle: F. — Last: Paul

4. DATE OF DEATH: Month: Nov. — Day: 14 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 29, 1891
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Electrician
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert F. Paul
14. MOTHER'S MAIDEN NAME: Emma Trought

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 579-05-0089A
17. INFORMANT: Myrtle B. Paul — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO
(b): Generalized Arteriosclerosis — 4 years
DUE TO
(c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 1960, to Nov. 14, 1960, that I last saw the deceased alive on Nov. 14, 1960, and that death occurred at 5:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John S. Rogers M.D. — ADDRESS (Street, city or town, state): 1317 Georgia Ave Silver Spring Md — DATE SIGNED: 11-17-60

PHYSICIAN'S NAME (Type): JOHN S. ROGERS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Nov. 17, 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W W Saltarelli — ADDRESS: 3603 14th St NW Wash. D.C.
24a. REC'D BY REGISTRAR: DATE NOV 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

12848

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12798

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seneca (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: Ada — Last: Peters

4. DATE OF DEATH: Month: November — Day: 13 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]
8. DATE OF BIRTH: February 6, 1876
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Collier
14. MOTHER'S MAIDEN NAME: Martha Berry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: (Nephew) Lawrence L. Collier — Address: 805 Wade Ave., Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hours.
DUE TO (b) Hypertension — 10 years
DUE TO (c) Hypertensive Cardiovascular disease — 7 years.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Right chamyelegia
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1953, to Nov 13, 1960 that I last saw the deceased alive on Nov 13, 1960, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Fawcett M.D. — ADDRESS (Street, city or town, state): Damsonville — DATE SIGNED: Nov 13, 1960
PHYSICIAN'S NAME (Type): John G. Fawcett — P. O. Boyd, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/16/60
22c. NAME OF CEMETERY OR CREMATORY: Darnestown Cemetery
22d. LOCATION (City, town, or county) (State): Darnestown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12849

CERTIFICATE OF DEATH

Reg. Dist. No. 12799

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Rockville
c. LENGTH OF STAY IN 1b: 3 weeks 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Waverley Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bronxville 8
d. STREET ADDRESS: 23 Cassilis Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

69X-3

3. NAME OF DECEASED (Type or print): First: Katherine; Middle: R.; Last: Peugnet

4. DATE OF DEATH: Month: 11; Day: 14; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 16, 1870

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City, N. Y.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George B. Robinson

14. MOTHER'S MAIDEN NAME: Lilla Bryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Louis P. Allwine — Address: 17411 Rockville Pike, Rockville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia, Terminal — 1 week
DUE TO
(b) Cerebral Thrombosis — 4 mo
DUE TO
(c) Generalized & Cerebral Arteriosclerosis — 15 yrs

332x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 23, 1960 to Nov 14, 1960 that I last saw the deceased alive on Nov 13, 1960, and that death occurred at 2:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Horace H. Curtis, M.D.
ADDRESS (Street, city or town, state): 1852 Columbia Rd NW
DATE SIGNED:
PHYSICIAN'S NAME (Type): HORACE H. CURTIS JR — WASH 9 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 11-15-1960
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): New York, N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc.
ADDRESS: 1756 Pa. Ave, NW. Wash. 6, D.C.
24a. REC'D BY REGISTRAR: DATE NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Clifford S. Keene

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1

12692

12880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2009 GRACE CHURCH ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 645 G St., S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4-7X-3

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle GOLDIE — Last PFEIFFER

4. DATE OF DEATH: Month NOV. — Day 18 — Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/11/86
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. THOMPSON
14. MOTHER'S MAIDEN NAME: MARY JANE MULLEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs. Louise P. McKenna, 2009 Grace Church Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	10 min
420.0 DUE TO (b)	Arteriosclerotic Heart disease	8 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/30/1954 to 11/18/1960 that (I) (we) last saw the deceased alive on 10/31/1960 and that death occurred at 8:10 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Russell B. Arnold M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 8801 Colesville Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/22/60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieka
ADDRESS: WARNER E. PUMPHREY, INC. SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE: NOV 28 60
25b. REGISTRAR'S SIGNATURE: Arthur J. Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12850

CERTIFICATE OF DEATH

12801

M

051

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2

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 8 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital Bethesda Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — COUNTY: District of Columbia — P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C.
d. STREET ADDRESS: 5036 Neptune Avenue — 1616-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Imogene — Middle: Frances — Last: Phelps
4. DATE OF DEATH: Month: November — Day: 11 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-17-25
9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinoise
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Doan
14. MOTHER'S MAIDEN NAME: Edna Courson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NA — (If yes, give war or dates of service): NA
16. SOCIAL SECURITY NO.: NA
17. INFORMANT: Louis R. Phelps (h) 5036 Neptune Ave Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
410X
DUE TO
(b) RHEUMATIC HEART DISEASE (Mitral Insufficiency) — 8 Years
DUE TO
(c) HEPATITIS, SERUM — 2 Weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-2- 1960 to 11-11 1960 that (I) (we) last saw the deceased alive on 11-11- 1960, and that death occurred at 5:45 AM from the causes and on the date stated above.

22a. SIGNATURE: James M. Young M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-11-60
22c. PHYSICIAN'S NAME (Type): James M. Young LT (MC) USN
22d. ADDRESS: U.S. NAVAL HOSPITAL BETHESDA MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 11-13-60
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Salem Illinois

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. A. Pimphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR: NOV 15 60 DATE
25b. REGISTRAR'S SIGNATURE: Clement L. Krause

VR A15 (4)
1SM 9/59

1

12851

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12802

M

074

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D

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 46 Bethesda
d. STREET ADDRESS: 8130 Old Georgetown Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter; Middle:; Last: Quinn
4. DATE OF DEATH: Month: November; Day: 28; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 21, 1883
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: School teacher
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick Quinn
14. MOTHER'S MAIDEN NAME: Ellen Holmes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 189205679
17. INFORMANT: John F. Quinn, son — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) Emphysema - Pneumonia
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9/16/1953 to 11/28/1960, that (I) (we) last saw the deceased alive on 11/28/1960, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. T. Joyce M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/28/60
22c. PHYSICIAN'S NAME (Type): W. T. JOYCE
22d. ADDRESS: 8106 Maple Ridge Rd., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 11-28-60
23c. NAME OF CEMETERY OR CREMATORY: St. Rose's Cemetery
23d. LOCATION (City, town, or county) (State): Carbondale, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

VR A1S (4)
1SM 9/59

1 X2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12740 12804

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: # 17 MAGNOLIA PARKWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE 53
d. STREET ADDRESS: # 17 MAGNOLIA PARKWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RALPH Middle W. Last RICHARDS
4. DATE OF DEATH: Month November Day 28 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/30/1879
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. GEOLOGIST
10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE
11. BIRTHPLACE (State or foreign country): MAINE
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ALBERT RICHARDS
14. MOTHER'S MAIDEN NAME: LYDIA McINTIRE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. MARIE DeB. RICHARDS, Address: SAME AS # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b) Coronary Heart Disease — 5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from January 1940 to November 28 1960 that (I) (~~we~~) last saw the deceased alive on 11-28 1960, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Michael J. McInerney MD M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-28-1960
22c. PHYSICIAN'S NAME (Type): MICHAIL J. McINERNEY, MD.
22d. ADDRESS: 1150 - CONN. AVENUE, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/1/60
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d. LOCATION (City, town, or county) (State): SUITLAND, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gentile's Inc ADDRESS: 1756 PA. AVE., N.W.
25a. REC'D BY REGISTRAR DATE: DEC 1 '60
25b. REGISTRAR'S SIGNATURE: Cathrine E. Krous

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

CERTIFICATE OF DEATH

12895

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dunedin
d. STREET ADDRESS: 2233 Baywood Drive, West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Warren — Last: Richards

4. DATE OF DEATH: Month: November — Day: 21 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 19, 1897
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: (Unknown)
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Richards
14. MOTHER'S MAIDEN NAME: Marian Webbe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Clinical Center, Bethesda 14, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour
DUE TO (b): Rheumatic Heart Disease, Inactive with calcific
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Aortic Stenosis, thickened insufficient Mitral Valve, thickened tricuspid valve, cardiac hypertrophy Atherosclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 13, 1960, to November 21, 1960, that I last saw the deceased alive on November 21, 1960, and that death occurred at 2:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Benson R. Wilcox M.D. — M.D.
ADDRESS (Street, city or town, state): The Clinical Center, Bethesda 14, Md. National Institutes of Health
DATE SIGNED: 11-21-60
PHYSICIAN'S NAME (Type): BENSON R. WILCOX, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/23/60
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
R. A. Pumphrey Funeral Home
24a. REC'D BY REGISTRAR DATE: NOV 23 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12853 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12803

Item 7 FilmG279 1-25-61 et

Reg. Dist. No.

Item 3 FilmG279 1-25-61 et

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 59 Bethesda
d. STREET ADDRESS: 6601 Goldsboro Ct.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jessie — Middle: Ray — Last: Robinson

4. DATE OF DEATH: Month: Nov. — Day: 19 — Year: 1960

5. SEX: female

6. COLOR OR RACE: col.

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ Sep. (Not a legal Sep.)

8. DATE OF BIRTH: 5/16/18

9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Ray

14. MOTHER'S MAIDEN NAME: Arelia Metts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Sister. Mrs. Frances Davies

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
(b) RUPTURE, LENTICULOSTRIATE ARTERIES, RIGHT — 2 hours
DUE TO
(c) HYPERTENSIVE CARDIOVASCULARRENAL DISEASE — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on floor at home & struck head against cabinet

20c. TIME OF INJURY Hour: 7 35 a.m. X p.m. — Month, Day, Year: 11/19/60

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) (County) (State): Bethesda Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 11/20/60

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 11-23-1960

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

22d. LOCATION (City, town, or county) (State): 4611 Benning Rd., S.E. Wash., D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: MALVAN & SCHEY, INC. — ADDRESS: 424 "R" St., N. W. Wash., D.C.

24a. REC'D BY REGISTRAR — DATE: NOV 22 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

12854

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12806

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 59 Bethesda.
d. STREET ADDRESS: 6724 - Wilson Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 074

3. NAME OF DECEASED (Type or print): First: Harry Middle: B. Last: Rosenberger
4. DATE OF DEATH Month: Nov. Day: 23 Year: 1960.

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 6/12/08
9. AGE (In years lost birthday): 52 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horticulturist
10b. KIND OF BUSINESS OR INDUSTRY: Nat'l Cathedral
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Rosenberger
14. MOTHER'S MAIDEN NAME: Harriet Kenworthy.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — If yes, give war or dates of service: no
16. SOCIAL SECURITY NO.: 166-07-9313
17. INFORMANT: Clara Rosenberger — Address: Same As Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONFLUENT BRONCHIOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: ONE DAY
DUE TO (b): Neoplastic Blood Disease, undetermined — 2 months
DUE TO (c): type

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 197.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from — 1951, to Nov 23, 1960, that (I) (we) last saw the deceased alive on Nov 23 1960, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE DeWitt E. DeLawter M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 11/23/60
22c. PHYSICIAN'S NAME (Type): DeWITT E. DeLAWTER
22d. ADDRESS: 8025 Aberdeen Rd. Bethesda, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11/26/60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12855

CERTIFICATE OF DEATH

Reg. Dist. No. 12807

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown
d. STREET ADDRESS R.F.D. #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Barbara Middle: G. Last: Ross
4. DATE OF DEATH Month: 11 Day: 22 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/12/1898
9. AGE (In years lost birthday): 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME: Arthur Gable
14. MOTHER'S MAIDEN NAME: Florence Brindel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 578-40-9388
INFORMANT: Hugh Ross (husband) Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pleural effusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b) Metastatic carcinoma of lungs + pleura — 3 weeks
DUE TO
(c) Carcinoma (adeno) of the breast — 2 years 6 mth

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1950 to Nov 22, 1960, that I last saw the deceased alive on 22 Nov, 1960, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John Fawcett M.D. ADDRESS (Street, city or town, state) DAWSONVILLE DATE SIGNED 11/22/60
PHYSICIAN'S NAME (Type) John G. Fawcett P.O. BOYD, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/25/60
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE NOV 28 '60
24b. REGISTRAR'S SIGNATURE Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12856 **CERTIFICATE OF DEATH** 12808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 yr 1 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V 01-4
d. STREET ADDRESS: 5211 Norwood Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Kathryn — Middle: F. — Last: Ruprecht

4. DATE OF DEATH: Month: Nov — Day: 16 — Year: 1960

5. SEX: F

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Mar 26, 1881

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Ford

14. MOTHER'S MAIDEN NAME: Roseann Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Madaline Robison — Address: 3620 Jocher Dr Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	2 days
DUE TO (b)	Cachexia	2 wk
DUE TO (c)	Psychotic Depression	1 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

401X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 7-7 1959 to 11-16 1960 that (I) (we) last saw the deceased alive on 11-15 1960 and that death occurred at 8:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Roy B Parsons Jr MD M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11-16-60

22c. PHYSICIAN'S NAME (Type): Roy B Parsons Jr MD

22d. ADDRESS: Burtonsville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/19/60

23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

23d. LOCATION (City, town, or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Tickner & Sons — ADDRESS: Balto 17, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 21 1960

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 15M 9/59

12857

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12810

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA (Rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USNH, NNMC, BETHESDA, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 4603 OVERBROOK AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

56

3. NAME OF DECEASED (Type or print): First: Ella Middle: May Last: ST. CLAIR
4. DATE OF DEATH Month: 11 Day: 24 Year: 1960

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-4-80
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: N.A.
11. BIRTHPLACE (State or foreign country): MISSISSIPPI
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lee Joyner
14. MOTHER'S MAIDEN NAME: Margaret E. Love

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: Official Navy Records Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (Probable Cerebral Thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: less than 1hr

331X

DUE TO (b) Cerebrovascular Arteriosclerosis — 9 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thromboses in 1951, April 1960.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-24 1960 to 11-24 1960 that (I) (we) last saw the deceased alive on 11-24- 1960, and that death occurred at 1:30AM from the causes and on the date stated above.

22a. SIGNATURE: John Wood Davis LT MC USN — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-24-60
22c. PHYSICIAN'S NAME (Type): J. W. DAVIS LT MC USN
22d. ADDRESS: USNH, NNMC, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 11-24-60
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town, or county) (State): Tutelo, Miss.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: R. A. PUMPHREY, FUNERAL HOME 7557 Wisc.Ave. BETHESDA, Md.
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Co. Deputy Medical Examiner notified and released to hospital.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12729 12869

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5612 - 1st Street N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Eva — Last: Salb
4. DATE OF DEATH: Month: November — Day: 26 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. - 1 - 1897
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hw.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Biggs
14. MOTHER'S MAIDEN NAME: ADDIE E. LENNOX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 11 hrs.
331X
DUE TO (b) Cerebral arteriosclerosis — 15 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Essential hypertension — 25 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aplastic anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-5, 1960 to 11-2, 1960 that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Samuel M Bagwant M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): 11-30-60
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: Timothy Houlon — ADDRESS: 3831 Ga. Ave. NW
25a. REC'D BY REGISTRAR: DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Howard

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12858 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12811

Reg. Dist. No.

Items 4,8,9,17 F11mG276 12-5-60 et

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5104 Viking Road

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE or COUNTRY: XXX CANADA b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Toronto 5
d. STREET ADDRESS: 50 St. Andrew's Gardens
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cicely Middle Noel Last SAVAGE
4. DATE OF DEATH: Month November Day 16 Year 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 25, 1889 (1887)
9. AGE (In years last birthday): 72 yrs. (73)
IF UNDER 1 YEAR: Months 10 Days 21
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): London, England
12. CITIZEN OF WHAT COUNTRY? Canadian
13. FATHER'S NAME: George William Henry French
14. MOTHER'S MAIDEN NAME: Emily Garland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter Address: Same as Item #1
Mrs. Rodger Anderson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: November 16, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-19-60
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Mongtomgery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE NOV 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kenny

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12750

CERTIFICATE OF DEATH

Reg. Dist. No. 12812

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10231 Carroll Place Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3416 Rittenhouse Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLEN Middle: B. Last: SCHERMER HORN
4. DATE OF DEATH: Month: November Day: 17 Year: 1960
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 20, 1859
9. AGE (In years last birthday): 101 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Robert Bell
14. MOTHER'S MAIDEN NAME: Katherine Boyd
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
INFORMANT: Records at Sanitarium — Address: Same as # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: YEARS
422.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from —, 1951, to November 17 1960, that I last saw the deceased alive on Nov 16, 1960, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: DeWitt E. DeLawter M.D. — ADDRESS (Street, city or town, state): 8025 ABERDEEN Rd — DATE SIGNED: 11-17-60
PHYSICIAN'S NAME (Type): DEWITT E. DELAWTER, M.D. — Bethesda 14, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/19/60
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14th St., N.W. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE NOV 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

VR A15 (-
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14593 **CERTIFICATE OF DEATH** 14596

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 4 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAVAREST NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. HYATTSVILLE
d. STREET ADDRESS: 6629 23rd PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1658-2

3. NAME OF DECEASED (Type or print): First Emma Middle Maria Elizabeth Last Schlenker
4. DATE OF DEATH: Month 11 Day 17 Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/5/66
9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: FRIEDRICH WILHELM KRUMM
14. MOTHER'S MAIDEN NAME: CATHARINA MARIE CHRISTINE PLATTHOFF
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Miss Anna A. Schlenker, 6629 23rd Pl. W. Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week
420.1
DUE TO (b) Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Atherosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1949 to Nov. 1960 that (I) (~~we~~) last saw the deceased alive on Nov 8 1960, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Maurice Franks M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Maurice Franks, M.D.
22d. ADDRESS: 901 20th NW, Wash 6, DC.

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
23b. DATE THEREOF: 11/21/60
23c. NAME OF CEMETERY OR CREMATORY: MT. WALLASTON CEMETERY
23d. LOCATION (City, town, or county) (State): QUINCY, MASS.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieka
WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE APR 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12730

CERTIFICATE OF DEATH

Reg. Dist. No. 12813

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedar Haven 7300 Ball Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 1704 Gilbert St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna Middle OLIVIA Last Senyohl
4. DATE OF DEATH: Month Nov Day 28 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Dec 5, 1879
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): DULUTH, MINN.
12. CITIZEN OF WHAT COUNTRY? YES U.S.A.
13. FATHER'S NAME: THEODORE SENYOHL
14. MOTHER'S MAIDEN NAME: ELIZABETH PETERSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 476-05-7375
17. INFORMANT: HOWARD C. CHISHOLM Address 704 GILBERT ST TAKOMA PARK 12, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
(b) Hypertension — years
DUE TO
(c) Arteriosclerosis — years

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 7, 1960, to Nov 28, 1960, that I last saw the deceased alive on Nov 8, 1960, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state): 918 Ellsworth Drive DATE SIGNED: 11/28/60

PHYSICIAN'S NAME (Type): Philip E. Jones Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/30/60
22c. NAME OF CEMETERY OR CREMATORY: GLENWOOD CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. POTTERSON, INC. Raymond A. Zeika ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE DEC 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12731 12814

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13½ hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address): Washington San + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: --
b. COUNTY: --
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D C. 47X-3
d. STREET ADDRESS: 3602 South Dakota Ave N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith Middle Amelia Last SHAFER
4. DATE OF DEATH: Month 11 Day 3 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-18-78
9. AGE (In years lost birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Buhler
14. MOTHER'S MAIDEN NAME: Elizabeth Horner.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Wash. San + Hosp Records. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 — DUE TO
(b) Myocardial infarction — 5 minutes
DUE TO
(c) ASHD C congestive failure — 6 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from June 1960 to 11/3 1960, that (I) (we) last saw the deceased alive on 11/3 1960, and that death occurred at 10:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/3/60
22c. PHYSICIAN'S NAME (Type): Hugh W. Irey
22d. ADDRESS: 7105 Riggs Road, Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 11/7/60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
23d. LOCATION (City, town, or county) (State): Ft. Myer, Va.
24. FUNERAL DIRECTOR'S SIGNATURE: S H Hines Co. ADDRESS: 2701 14th NW
25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

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051

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12859

12815

48x3

1. **PLACE OF DEATH** a. COUNTY: Montgomery **MARYLAND**	2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Florida b. COUNTY: Dade
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)	c. LENGTH OF STAY IN 1b: 96 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Opa-Locka	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital	d. STREET ADDRESS: 2821 NW 154th Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	

3. **NAME OF DECEASED** (Type or print) First: Harold Middle: Cleaves Last: SHAW

4. **DATE OF DEATH** Month: November Day: 18 Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-9-86

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months ___ Days ___ IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles SHAW

14. MOTHER'S MAIDEN NAME: Alma PRESTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI & WWII

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Hospital Records Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma with

162.1

DUE TO (b) cerebral metastases

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify that** ~~I~~ (this hospital) attended the deceased from August 14 1960 to Nov. 18 1960, that ~~I~~ (we) last saw the deceased alive on Nov. 18 1960, and that death occurred at 11:50PM ___M, from the causes and on the date stated above.

22a SIGNATURE: J M Young M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-19-60

22c. PHYSICIAN'S NAME (Type): J. M. YOUNG, LT MC, USN
~~XXXXXXXXXXXXXXXXXXXXXXXXX~~

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 11-21-60

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hills Crematory

23d. LOCATION (City, town, or county): Suitland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: R A Pumphrey ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kenes

2

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BP

TO HOSPITAL [illegible] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retai[illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b[illegible]e funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12860

CERTIFICATE OF DEATH

12816
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD Germantown

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Damascus
d. STREET ADDRESS: RFD Germantown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ollie; Middle: M.; Last: Shaw

4. DATE OF DEATH: Month: Nov.; Day: 30; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 6, 1878

9. AGE (In years lost birthday): 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Colesville, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward Shaw

14. MOTHER'S MAIDEN NAME: Mary V. Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Yes ?

INFORMANT: Mrs Elsie R. Shaw, Gaithersburg, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: Months
153.8
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 5, 1960, to Nov. 30, 1960, that I last saw the deceased alive on Nov. 29, 1960, and that death occurred at 8:10 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D.
ADDRESS (Street, city or town, state): 105 Russell Ave., Gaithersburg, Md.
DATE SIGNED: 12-2-60
PHYSICIAN'S NAME (Type): Jack Schumacher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 3, 1960

22c. NAME OF CEMETERY OR CREMATORY: Derwood

22d. LOCATION (City, town, or county) (State): Derwood, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Mohrmann
ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE DEC 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12732 **CERTIFICATE OF DEATH** 12817

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 34 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 310 LINCOLN AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 310 LINCOLN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HERMAN Middle OTTO Last SIKORRA
4. DATE OF DEATH: Month NOVEMBER Day 30 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPTEMBER 24, 1889
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUDITOR
10b. KIND OF BUSINESS OR INDUSTRY: BANK
11. BIRTHPLACE (State or foreign country): CAVOUR SOUTH DAKOTA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: AUGUST SIKORRA
14. MOTHER'S MAIDEN NAME: AUGUSTA KOSCHESKI
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 579-05-2034
17. INFORMANT: EMILY M. SIKORRA — Address: 310 LINCOLN AVE. TAKOMA PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (b) Coronary arterial sclerosis — 1 yr
DUE TO (c) Generalized cardio-vasc. dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Sept 1960 to Nov 1960 that (I) (we) last saw the deceased alive on 30 Nov 1960 and that death occurred at 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Ernest E. Harmon M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/30/60
22c. PHYSICIAN'S NAME (Type): ERNEST E. HARMON M.D.
22d. ADDRESS: 9301 Colesville Rd. Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DECEMBER 3, 1960
23c. NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON
23d. LOCATION (City, town, or county) (State): ADELPHI, MARYLAND.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 CARROLL ST. N.W. - WASH. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 2 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12693

CERTIFICATE OF DEATH

12818

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. **PLACE OF DEATH** a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 14 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12,818 Flack Street

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 SILVER SPRING
d. STREET ADDRESS: 12,818 Flack Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARIETTA Middle: Last: SINOPOLI
4. **DATE OF DEATH**: Month: NOV. Day: 4 Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/21/81
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: LEANORDO SINOPOLI
14. MOTHER'S MAIDEN NAME: ROSA COLOSIMO
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 082-01-0830-A
17. **INFORMANT**: Mr. Jack Sinopoli, 12,818 Flack St. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b) Cerebral Arteriosclerosis — 4-5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 1957, to Nov 4 1960, that (I) (~~we~~) last saw the deceased alive on Nov 4 1960, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Morris Perry M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: NOV 4, 1960
22c. PHYSICIAN'S NAME (Type): MORRIS PERRY
22d. ADDRESS: 11602 Ga. Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/7/60
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zuska
WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12694

CERTIFICATE OF DEATH

Reg. Dist. No. 12819

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 702 LANARK WAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 30
d. STREET ADDRESS: 702 Lanark Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Hilliard Last Snouffer
4. DATE OF DEATH: Month Nov. Day 10 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 13, 1866
9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (RETIRED)
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: George Fenton Snouffer
14. MOTHER'S MAIDEN NAME: Mary Hebb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs R. Talbott Address: Gaithersburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolii — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b): Congestive Cardiac Failure — years
DUE TO
(c): Pneumonia — 6 days

434.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 4, 1960, to Nov. 10, 1960, that I last saw the deceased alive on Nov 10, 1960, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state): 918 Ellsworth Drive DATE SIGNED: 11/10/60

PHYSICIAN'S NAME (Type): Philip E. Jones Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/12/60
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD. Raymond A. Ziska
24a. REC'D BY REGISTRAR DATE NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12751

CERTIFICATE OF DEATH

Reg. Dist. No. 12820

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10231 Carroll Place Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: --
b. COUNTY: --
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1423 Madison Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

050

3. NAME OF DECEASED (Type or print): First: Hector; Middle: G.; Last: Spaulding

4. DATE OF DEATH: Month: Nov; Day: 6; Year: 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 8/2/1879

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Professor of Law-

10b. KIND OF BUSINESS OR INDUSTRY: G.W.University

11. BIRTHPLACE (State or foreign country): Fargo North Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry Spaulding

14. MOTHER'S MAIDEN NAME: Lucretia Galloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

INFORMANT: John Spaulding — Address: 4315 Chestnut Street Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure and shock — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b): Pyelonephritis and urinary retention — 10 days
~~DUE TO~~
(c): arteriosclerotic cardiovascular disease — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

600.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gout; Pernicious anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC. 20, 1959, to NOV. 5, 1960 that I last saw the deceased alive on NOV. 5, 1960, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Youngblood M.D. — ADDRESS (Street, city or town, state): WASHINGTON CLINIC — DATE SIGNED:

PHYSICIAN'S NAME (Type): EDWARD W. YOUNGBLOOD — WASHINGTON 15, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 11/9/1960

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co — ADDRESS: 2901 14th St N.W.

24a. REC'D BY REGISTRAR DATE: NOV 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12861

Reg. Dist. No. 12821

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10301 Eastwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle L Last SPROUSE

4. DATE OF DEATH: Month NOV. Day 20 Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11/8/87

9. AGE (In years lost birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Coal miner)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Sprouse.

14. MOTHER'S MAIDEN NAME: Mary Agnes Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 236-10-8110

INFORMANT: Lola W. Sprouse — Address: Same as Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b) Rupture, Aneurysm of Arteria Communicating Artery — Unknown
DUE TO
(c)

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from NOV 18, 1960, to NOV 20, 1960, that I last saw the deceased alive on NOV 20, 1960, and that death occurred at 2:05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A. Beeman M.D. — ADDRESS (Street, city or town, state): 10620 GEORGIA AVE. — DATE SIGNED:

PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN SILVER SPRING MD

Edward A. Beeman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 23, 1960

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: NOV 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12695 **CERTIFICATE OF DEATH** 12822

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8806 GLENVILLE ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8806 GLENVILLE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle HOBAN Last STANFORD
4. DATE OF DEATH: Month NOV. Day 25 Year 19 60
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/19/96
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOK-BINDER
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. Gov't. Printing Office
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN STANFORD
14. MOTHER'S MAIDEN NAME: ELLEN unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW # 1
16. SOCIAL SECURITY NO.: 195-10-5212
17. INFORMANT: Mrs. Margaret I. Stanford, 8806 Glenville Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UNDIFFERENTIATED CARCINOMA Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 YRS
DUE TO (b) GENERALIZED METASTASES & CACHEXIA — 6MO-1YR.
DUE TO (c) TERMINAL EMACIATION AND DEBILITY — 6WKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): "AS ABOVE"

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 19 56 to Nov. 25 19 60 that (I) (we) last saw the deceased alive on Nov. 25 19 56 and that death occurred at 6:20 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas F. Quinn M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): THOMAS F. QUINN MD.
22d. ADDRESS: 501-B-Southampton DRIVE SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/29/60
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
23d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Ziska
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE DEC 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12823

CERTIFICATE OF DEATH

12696

M

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 904 HIGHLAND DR.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 SILVER SPRING
d. STREET ADDRESS 1904-HIGHLAND DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print) First LIBBY Middle — Last STEINBERG
4. DATE OF DEATH Month NOV Day 15 Year 1960
5. SEX F
6. COLOR OR RACE WH
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 12-15-1893
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME REBECCA - (UNKNOWN)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT ALFRED STEINBERG Address 904 Highland Dr SSPG MD

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH 5 min.
332X
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) RHEUMATIC HEART DISEASE, HEMIPLEGIA 13 yrs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUG 27 1960, to NOV 15 1960, that (I) (we) last saw the deceased alive on 11/12 1960, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE Morton H Rose M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) MORTON H ROSE
22d. ADDRESS 1801 EYE ST NW WASH DC.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 11-18-1960
23c. NAME OF CEMETERY OR CREMATORY NATL MEM. PARK
23d. LOCATION (City, town, or county) (State) FALLS CH. VA.

24. FUNERAL DIRECTOR'S SIGNATURE Goodley Funeral Home
ADDRESS 4217-9th Ave
25a. REC'D BY REGISTRAR DATE NOV 21 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12862 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12824

M 03 I 0 2 BP

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Washington~~ — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 733 Otis Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X -2

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Sterling — Last:
4. DATE OF DEATH: Month: 11 — Day: 7 — Year: 19 60
5. SEX: F
6. COLOR OR RACE: Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/28/17
9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Fortune
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Doratha Evans (Item #2) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11/7/60
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/11/60
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial.,
22d. LOCATION (City, town, or country) (State): Suitland, Md.
23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR — DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12863 **CERTIFICATE OF DEATH** 12825

1. PLACE OF DEATH
a. COUNTY: Montgomery county, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5863 Chevy Chase Parkway, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Mrs. Middle: Carrie Johnson Last: Stone

4. DATE OF DEATH: Month: November Day: 9 Year: 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: May 28, 1883
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Secretary
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fitchburg, Mass.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank P. Johnson
14. MOTHER'S MAIDEN NAME: Elizabeth Freeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 018 01 4651
17. INFORMANT: hospital records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF COLON — INTERVAL BETWEEN ONSET AND DEATH: 3 YRS
153.8
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUG 23 1960 to NOV 9 1960, that (I) (we) last saw the deceased alive on Nov 9 1960 and that death occurred at 3:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Leo M. Curtis M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/9/60
22c. PHYSICIAN'S NAME (Type): Dr. Leo Curtis
22d. ADDRESS: 8218 Wisconsin Ave. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: 11/11/60
23c. NAME OF CEMETERY ~~OR CREMATORY~~: FOREST HILL
23d. LOCATION (City, town, or county) (State): Fitchburg, Mass

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons
ADDRESS: 1734 Pa. Ave. N.W. DC
25a. REC'D BY REGISTRAR DATE: NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Clifford E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12864 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12826

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: R-4
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Roland Middle E Last Stull
4. DATE OF DEATH: Month Nov Day 16 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 3/4/193
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farm Work
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clinton Eugene Stull
14. MOTHER'S MAIDEN NAME: Rosa Ann Howard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-30-0914
17. INFORMANT: Mrs. Dora Tasker, Address: 2120 Westchester Ave. Catonsville 28 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple fractures Left Pelvis — INTERVAL BETWEEN ONSET AND DEATH
816X
DUE TO (b) (Pubis, Ileum and Ischium)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Fracture base of Skull (Sphenoid Bone)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MV & MV
Driver of auto involved in auto accident
20c. TIME OF INJURY Hour 10:30 a.m. Month, Day, Year 11-16 1960
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Clarksville (County) Howard (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: 11-17-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-19-60
22c. NAME OF CEMETERY OR CREMATORY: St. Marks
22d. LOCATION (City, town, or country) (State): Ellicott City, Md
23. FUNERAL DIRECTOR: F.C. Higinbothom, ADDRESS: Ellicott City, Md
24a. REC'D BY REGISTRAR DATE NOV 21 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krause
NOV 21 '60 Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12697 12827

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1825 Tilton Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1825 Tilton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES Middle MAY Last SULLIVAN
4. DATE OF DEATH: Month NOV. Day 13 Year 19 60
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/28/86
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): MASS.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: DANIEL DURNING
14. MOTHER'S MAIDEN NAME: ANNIE FERGUSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mr. John J. Sullivan, 1825 Tilton Dr. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

782.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Dec 7 1956 to Nov 13 1960 that (I) (we) last saw the deceased alive on Nov 13 1960, and that death occurred at 7:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-13-60
22c. PHYSICIAN'S NAME (Type): EDWARD J. RICHARDS
22d. ADDRESS: 10,110 Ga. Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/16/60
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zuska ADDRESS: WARNER E. PUMPHREY, INC. SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 17 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12865 **CERTIFICATE OF DEATH** 12828

Item 1 FilmG275 11-28-60 et
Items 8,9 FilmG277 12-

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. (MARYLAND)
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 5306 Kenwood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth Middle: I Last: Sullivan
4. DATE OF DEATH: Month: Nov. Day: 18 Year: 1960
5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 27 1895 1905
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months 10 Days 21 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Business Forms
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Kathryn Drake Friend Address: 5904 Ryland Dr. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: immed.
DUE TO
(b) arteriosclerotic heart disease — 3 yrs.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1957 to Nov 18 1960 that (I) (we) last saw the deceased alive on Nov 18 1960 and that death occurred at 1:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wilfred R. Ehrmantraut M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut M.D.
22d. ADDRESS: 4890 Battery Lane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/22/60
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town, or county) (State): Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12866

CERTIFICATE OF DEATH

Reg. Dist. No. 12829

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montg

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds Rural

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montg, Co. General Hosp,

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: James Middle: Earl Last: Sutphin

4. DATE OF DEATH: Month: Nov Day: 20 Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 26-1923

9. AGE (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months: 6 Days: 24 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Vicker. Va.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Stanford E. Sutphin

14. MOTHER'S MAIDEN NAME: Trophy Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Lois U. Sutphin. Address: Boyds. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Synovioma, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO (b) retroperitoneal — 7 years
DUE TO (c) Primary, right foot

227X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia, Secondary to Part 1a.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19____, to Nov. 20, 1960 that I last saw the deceased alive on Nov. 20, 1960, and that death occurred at 4:20 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. ADDRESS (Street, city or town, state): 105 Russell Ave. Gaithersburg, Md. DATE SIGNED: 11-21-60

PHYSICIAN'S NAME (Type): Jack Schumacher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-23-60

22c. NAME OF CEMETERY OR CREMATORY: Forest Oak

22d. LOCATION (City, town, or county) (State): Gaithersburg. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.

24a. REC'D BY REGISTRAR DATE: NOV 23 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12867 12830

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b: ½ day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Haney Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brownningsville
d. STREET ADDRESS: RFD # 1, Monrovia
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Edwin — Last Tabler
4. DATE OF DEATH: Month 11 — Day 15 — Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1899
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - well driller
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fred. Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Lewis Tabler
14. MOTHER'S MAIDEN NAME: Mary Vennie Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-12-0165
17. INFORMANT: Mrs Fannie Tabler — Address: Monrovia, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-15-60
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/18/60
22c. NAME OF CEMETERY OR CREMATORY: Hyattstown Meth.
22d. LOCATION (City, town, or county) (State): Hyattstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth
ADDRESS: Damascus. Md.
24a. REC'D BY REGISTRAR: DATE NOV 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1

12698

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12831

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAVA REST NURSING HOME 571 Univ. Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15
d. STREET ADDRESS: Boeteler Road 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle Ovelton Last TALBOTT

4. DATE OF DEATH: Month NOV. Day 20 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 6 1878
9. AGE (In years lost birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): County Worker
10b. KIND OF BUSINESS OR INDUSTRY: County Govt.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Talbott
14. MOTHER'S MAIDEN NAME: Susan Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE —
17. INFORMANT: Hazel Boeteler Address: Boeteler Rd, Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
331X
DUE TO (b) Generalized Arteriosclerosis — 10 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 5, 1960, to Nov. 20, 1960, that I last saw the deceased alive on Nov. 18, 1960, and that death occurred at 3:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Laubach M.D. ADDRESS (Street, city or town, state): 1806 Fox St, Hyattsville, Maryland DATE SIGNED: 11/20/60

PHYSICIAN'S NAME (Type): JAMES L. LAUBACH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/23/60
22c. NAME OF CEMETERY OR CREMATORY: COLESVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond W. Gorka
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Hinman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12699 12832

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1800 Grace Church Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: ~~MX~~ D. C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3040 Oliver Street, F. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First JOHN Middle Peter Last TALTY
4. DATE OF DEATH: Month Nov. Day 18, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/8/1870
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months 9 Days 10 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur-retired
10b. KIND OF BUSINESS OR INDUSTRY: Driving
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John Talty
14. MOTHER'S MAIDEN NAME: Mary Cushing
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Joseph Greco-son in law-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO (b) Cerebral Arteriosclerosis — 5 years
DUE TO (c) Generalized Arteriosclerosis

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/10/ 1960, to 11/18/ 1960, that (I) (we) last saw the deceased alive on 11/17/ 1960 and that death occurred at 12:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: E. Stuart Lyddane M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-18-60
22c. PHYSICIAN'S NAME (Type): E. STUART LYDDANE
22d. ADDRESS: 3066 Q St., N. W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/21/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12868 12833

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5415 Harwood Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Bethesda
d. STREET ADDRESS: 5415 Harwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Carson Last: TATUM
4. DATE OF DEATH: Month: November Day: 24 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/26/1911
9. AGE (In years lost birthday): 49 yrs. IF UNDER 1 YEAR: Months 7 Days 28 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Agent-Manufact.
10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Charles G. Tatum
14. MOTHER'S MAIDEN NAME: Bess Carson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 289-07-6970
17. INFORMANT: Francis Tatum, wife, same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Arteriosclerotic Heart Disease — One year
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11-14 1960, to 11-24 1960, that (I) (we) last saw the deceased alive on 11-18 1960, and that death occurred at 9:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert J. McCarthy M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-24-60
22c. PHYSICIAN'S NAME (Type): Robert J. McCarthy
22d. ADDRESS: 1801 EYE St N.W. WASH, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/26/60
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town, or county) (State): Rockville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12757

CERTIFICATE OF DEATH

12854

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 13215 Midway Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 13215 Midway Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle W. Last THOMPSON

4. DATE OF DEATH: Month November Day 15, Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4, 1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thompson

14. MOTHER'S MAIDEN NAME: Catherine Lindsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-10-2116

INFORMANT: Katherine M. Thompson — Address: Item# 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
540.0
DUE TO
(b) Ruptured peptic ulcer — 1 year
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/2/58, 19____, to 11/15/60 19____, that I last saw the deceased alive on 11/15/60, 19____, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Patrick C Jameson M.D. ADDRESS (Street, city or town, state): 12020 Georgia Avenue Wheaton Md DATE SIGNED: 11/15/60

PHYSICIAN'S NAME (Type): Patrick C. Jameson- 12020 Georgia Ave., Wheaton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/18/60

22c. NAME OF CEMETERY OR CREMATORY: St. John's

22d. LOCATION (City, town, or county) (State): Forest Glen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave., Rockville, Md.

24a. REC'D BY REGISTRAR: DATE NOV 17 '60

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1 X M 074 I 2 1

12869

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12865

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7509 - Jackson Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: Mary; Last: Thompson
4. DATE OF DEATH: Month: Nov.; Day: 23; Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/8/95
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Book Keeper
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Warner Wildonger
14. MOTHER'S MAIDEN NAME: Angie Crane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-09-3800 B
17. INFORMANT: George T. Thompson — Address: Same as Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b): Hypertensive cardio vascular-renal — 10 yrs.
DUE TO (c): disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1958, to Nov 22 1960, that (I) (we) last saw the deceased alive on Nov. 22 1960 and that death occurred at 8:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Philip H. Varner, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-23-60
22c. PHYSICIAN'S NAME (Type): Philip H. Varner.
22d. ADDRESS: 10620 Ga. Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
23b. DATE THEREOF: 11/26/60
23c. NAME OF CEMETERY OR CREMATORY: MOUNT PEACE CEMETERY
23d. LOCATION (City, town, or county) (State): PHILADELPHIA, PENNSYLVANIA

24. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A. Zuska
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR: DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12700

CERTIFICATE OF DEATH

12836

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8422 11th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy; Middle: May; Last: Thompson
4. DATE OF DEATH: Month: 11; Day: 15; Year: 1960
5. SEX: F
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-7-82
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Crawford Phillips
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Washington Sanitarium + Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(a) Cerebral Thrombosis c Infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO
(b) Cerebral Arteriosclerosis
DUE TO
(c)
332
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov 4 1960, to Nov 15 1960, that (I) (we) last saw the deceased alive on 11/15 1960, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Boris Rabkin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/15/60
22c. PHYSICIAN'S NAME (Type): BORIS RABKIN
22d. ADDRESS: 1019 University Blvd East

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 17. 1960
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Pr. Geo. Co. Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. NW. D.C.
26a. REC'D BY REGISTRAR — DATE: NOV 17 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12870

CERTIFICATE OF DEATH

Reg. Dist. No. 12837

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 207 WILLIAMSBURG DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BARBARA — Middle — Last TURKAL

4. DATE OF DEATH: Month 11 — Day 5 — Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/9/69
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
INFORMANT: Mr. M. James Turkal, 207 Williamsburg Dr. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1-2 mo
450.10
DUE TO (b) Arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Amputation Rt. leg above knee 11/3/60
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 57, to 5 Nov, 19 60 that I last saw the deceased alive on 5 Nov, 19 60, and that death occurred at 4:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Aud M.D. — ADDRESS (Street, city or town, state): 906 Colesville Rd Silver Spring Md — DATE SIGNED: 11/5/60

PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/8/60
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Geo. County, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Jeska — WARNER E. PUMPHREY, INC. — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12733 Reg. Dist. No. 12838

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7801 GARLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 7801 GARLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First GRACE Middle ANN Last TURNER
4. DATE OF DEATH: Month Nov Day 23 Year 1960
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Feb. 11 1880
9. AGE (In years lost birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WM DALE QUANTRILLE
14. MOTHER'S MAIDEN NAME: A. VICTORIA THOMAS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Shutdown with Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
450.0
DUE TO (b) Senile Arteriosclerosis — 5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma of Labia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1960, to 23 Nov, 1960, that I last saw the deceased alive on 22 Nov, 1960, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Queen M.D. ADDRESS (Street, city or town, state): 7112 Willow Ave DATE SIGNED: 23 Nov 1960
PHYSICIAN'S NAME (Type): H. B. QUEEN M.D. TAKOMA PARK, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Nov. 25, 1960
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): PG AVE EXTENDED PG.CO. Md.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walter ADDRESS: 254 Carroll St NW DC
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12871 12839

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Col.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 924 Southern Ave. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle James Last Twilley
4. DATE OF DEATH: Month Nov. Day 21 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20, 1886
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John W. Twilley
14. MOTHER'S MAIDEN NAME: Emma L. Forbes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: 579-07-3954
17. INFORMANT: Eva L. Twilley Address: Same as Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b) Obstruction Superior Vena Cava — 2 Months
DUE TO (c) Bronchogenic Carcinoma — 12 Months

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1958, 19__, to November 21, 1960, that (I) (~~we~~) last saw the deceased alive on Nov. 21, 1960, and that death occurred at 01:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Jack Crowell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JACK CROWELL
22d. ADDRESS: 2025 Eye St., N.W. Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov 25-60
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros
ADDRESS: 1661-gd Hope Rd S.E. West DC
25a. REC'D BY REGISTRAR DATE NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12734 12840

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1725 College View Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Michael; Last: Ulias
4. DATE OF DEATH: Month: 11; Day: 24; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 ~~[illegible]~~ - '07
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Cap. Nat'l. Parks Dept. of Interior
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? Amer.
13. FATHER'S NAME: John Ulias
14. MOTHER'S MAIDEN NAME: Dembiczak Sophia ~~[illegible]~~
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 207-05-0055
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
527.2
DUE TO (b): Secondary polycythemia — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): miliary granulomatous pulmonary disease, cause unknown — years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cirrhosis of liver.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov 2, 1960, to Nov 24, 1960, that (I) (we) last saw the deceased alive on Nov 23, 1960, and that death occurred at 12:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Sydney Leventhal, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Sydney Leventhal, M.D.
22d. ADDRESS: 9210 Colesville Rd, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/26/60
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
23d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Gioka — WARNER E. PUMPHREY, INC.
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

VR A1S (4) 1SM 9/59

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12741 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12841

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7039 Strathmore St

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Chevy Chase
d. STREET ADDRESS: 7039 Strathmore St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willard — Middle: Bart — Last: Upright
4. DATE OF DEATH: Month: Nov — Day: 8 — Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-18-04
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months 10, Days 20 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): draftsman
10b. KIND OF BUSINESS OR INDUSTRY: Drafting
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Willard S. Upright
14. MOTHER'S MAIDEN NAME: Mary Lambert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 578-05-2908
17. INFORMANT: Ruth E. Upright-wife-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 11-8-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 11/10/60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or country) (State): Suitland, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE NOV 10 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12872 12842

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Puerto Rico b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rio Piedras
d. STREET ADDRESS: 54 Balboa Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

89X-3

3. NAME OF DECEASED (Type or print): First: Frank Middle: Charles Last: URGELL

4. DATE OF DEATH Month: November Day: 7 Year: 19 60

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-4-92
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Educator
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Dept. of State
11. BIRTHPLACE (State or foreign country): Puerto Rico
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Bonocio URGELL
14. MOTHER'S MAIDEN NAME: Conception RAVENTOS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: (S) Frank G. Urgell, 1633 L St., NW, WashDC Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Coronary Atherosclerosis — Sev. years
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~[illegible]~~ attended the deceased from Oct. 13 19 60 to Nov. 7 1960, that (I) ~~saw~~ last saw the deceased alive on Nov. 7 19 60, and that death occurred at 8:40AM, from the causes and on the date stated above.

22a. SIGNATURE: F. H. O'Connell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-7-60
22c. PHYSICIAN'S NAME (Type): F. H. O'CONNELL, LCDR, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 11-9-60
23c. NAME OF CEMETERY OR CREMATORY: Puerto Rico Memorial Cem.
23d. LOCATION (City, town, or county) (State): San Juan Puerto Rico
24. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey ADDRESS: Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Chichuy S. Kwan

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12873 **CERTIFICATE OF DEATH** 12843

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 3018 Aberdeen Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen; Middle: Cuthpert; Last: VAN KEUREN

4. DATE OF DEATH: Month: November; Day: 27; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-2-82

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert MOLTEN

14. MOTHER'S MAIDEN NAME: Alice LALOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: (H) RADM Alexander Van Keuren, USN, Ret. Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
540.0
DUE TO (b) Post-operative bleeding duodenal ulcer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Nov. 23 19 60 to Nov. 27 19 60 that ☒ (we) last saw the deceased alive on Nov. 27 1960, and that death occurred at 8:10AM M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford M Herman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11-27-60

22c. PHYSICIAN'S NAME (Type): Clifford M. HERMAN, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-1-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. A. Pumphrey Funeral Home R. A. Pumphrey Funeral Home, Bethesda, Md.

25a. REC'D BY REGISTRAR DATE NOV 29 '60

25b. REGISTRAR'S SIGNATURE: Chester S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12874 **CERTIFICATE OF DEATH** 12844

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 52 Chevy Chase, MD.
d. STREET ADDRESS: 7501 Wyndale Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louise Middle — Last Veihmeyer
4. DATE OF DEATH: Month Nov. Day 4 Year 19 60
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4, 1888
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Pr. High Teacher
11. BIRTHPLACE (State or foreign country): Washington, DC
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: J. Oliver Veihmeyer
14. MOTHER'S MAIDEN NAME: Nellie Leavy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Helen Holmes - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO
(b) Hypertensive Cardio Renal Disease — 10 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/21 1960 to 11/4 1960 that (I) (we) last saw the deceased alive on 11/4 1960 and that death occurred at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Alvin I Kay M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/5/60
22c. PHYSICIAN'S NAME (Type): Alvin I Kay MD
22d. ADDRESS: 1835 Eye St NW

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11-8-60
23c. NAME OF CEMETERY OR CREMATORY: Mt. OLIVET CEMETERY
23d. LOCATION (City, town, or county) (State): WASHINGTON, D. C.
24. FUNERAL DIRECTOR'S SIGNATURE: F. J. Collins ADDRESS: WASH. D.C.
FRANCIS J. COLLINS 3821 14Th. ST. N.W.
25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 18 Film 275
11-29-60 ams

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12845

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Film 0276 12-5-60 et

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church (Rural) 22X-3
d. STREET ADDRESS: 351 Munson Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: Todd — Last: Venneman

4. DATE OF DEATH: Month: November — Day: 16 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 6, 1906

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Statistician

10b. KIND OF BUSINESS OR INDUSTRY: U.S. (Unknown) Gov.

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Luther E. Todd

14. MOTHER'S MAIDEN NAME: Lee Wheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: None 579-05-8389

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 Months
DUE TO
(b) Widespread Metastatic Carcinoma of Breast — 7 Years
DUE TO
(c)

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Status Post Hypophysectomy Hypophysectomy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8 November 19 60 to 16 November 19 60 that (I) (we) last saw the deceased alive on 16 November 19 60, and that death occurred at 7:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Leo Stolbach M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Leo L. Stolbach

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11-18-1960

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY

23d. LOCATION (City, town, or county) (State): ARLINGTON, VA.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons Inc. — ADDRESS: 1756 Pa. Ave N.W. Wash. D.C.

25a. REC'D BY REGISTRAR: DATE NOV 18 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

12735

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12846

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 34
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION: Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 3913 Littleton St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Letta Middle: Melvina Last: Walliker
4. DATE OF DEATH: Month: Nov. Day: 4 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-21-79
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Knut Liguin
14. MOTHER'S MAIDEN NAME: Eliza ? (unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — 20 days
DUE TO
(b) Arteriosclerosis, generalized — unknown
DUE TO
(c)
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 10/10 1960 to 11/4 1960, that (I) (~~we~~) last saw the deceased alive on 11/3 1960, and that death occurred at 7:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 11/4/60
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 918 Univ. Blvd. E. Silv. Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 23b. DATE THEREOF: 11-5-60
23c. NAME OF CEMETERY OR CREMATORY: Springdale Cemetery
23d. LOCATION (City, town, or county) (State): Clinton, Iowa

24. FUNERAL DIRECTOR'S SIGNATURE: R. A. Humphrey ADDRESS: 7557 Wisconsin Bethesda Md.
25a. REC'D BY REGISTRAR: NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12876 Reg. Dist. No. 12847

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna, 63x-3
d. STREET ADDRESS: 510 Walker Street, S.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Alice Last Wampler
4. DATE OF DEATH: Month November Day 8 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 24, 1919
9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Federal Government
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William R. Stephens
14. MOTHER'S MAIDEN NAME: Ethel Bank
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, due to Pseudomonas — INTERVAL BETWEEN ONSET AND DEATH: 5 days

2043

DUE TO (b) Acute Myelogenous Leukemia — 3 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 18, 1960 to November 8, 1960, that I lost saw the deceased alive on November 8, 1960, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Walter Oppelt M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 11-9-60
PHYSICIAN'S NAME (Type): W. WALTER OPPELT, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 12, 1960
22c. NAME OF CEMETERY OR CREMATORY: Linville Creek Church
22d. LOCATION (City, town, or county) (State): Broadway, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Money & King Chas Davis ADDRESS: Vienna, Virginia
24a. RECD BY REGISTRAR DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12877 12848

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 18 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, MD
d. STREET ADDRESS: 709 DOUGLAS AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NATHANIEL Middle: Last: WARREN
4. DATE OF DEATH: Month: NOV Day: 29 Year: 1960
5. SEX: MALE
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/28/98
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: FEED Comp.
11. BIRTHPLACE (State or foreign country): Rockville, Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Charles H. Warren
14. MOTHER'S MAIDEN NAME: Melinda Lee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles Warren Address: Brother Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
DUE TO (b) MYOCARDIAL INFARCTION — 24 HRS.
DUE TO (c) ATHEROSCLEROTIC HEART DISEASE — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): UNKNOWN

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from NOV 28 1960, to NOV 29 1960, that (I) (we) last saw the deceased alive on NOV 29 1960, and that death occurred at 3:54 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward A. Beeman M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN
22d. ADDRESS: 10620 GEORGIA AVE. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/3/60
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park.,
23d. LOCATION (City, town, or county) (State): Rockville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: DEC 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

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12849

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

M

073

1

2

1

BP

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 53 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GERMANTOWN
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY — Middle JOHNSON — Last WASHINGTON

4. DATE OF DEATH: Month NOVEMBER — Day 19, — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11- 1916

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: MARYLAND

11. BIRTHPLACE (State or foreign country): USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown JOHNSON

14. MOTHER'S MAIDEN NAME: ISABELL DORSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL RECORDS, OLNEY, MARYLAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant hypertension
DUE TO
(b) Arteriolar Nephrosclerosis
DUE TO
(c) Bilateral Pulmonary edema (marked)

445X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 11/17/ 1960, to 11/19/ 1960, that (I) (we) last saw the deceased alive on 11/19 1960, and that death occurred at 12:29AM from the causes and on the date stated above.

22a. SIGNATURE: G. F. Meadors M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 11/22/60

22c. PHYSICIAN'S NAME (Type): G. F. MEADORS, MD

22d. ADDRESS: DAMASCUS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11/22/60

23c. NAME OF CEMETERY OR CREMATORY: St. Marks Cemetery

23d. LOCATION (City, town, or county) (State): Boyd, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md

25a. REC'D BY REGISTRAR DATE NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur J. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12879

CERTIFICATE OF DEATH

12850

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 18 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4851 Sedgewick St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

M

051

I

3. NAME OF DECEASED (Type or print): First: Frances; Middle: Work; Last: WEBB

4. DATE OF DEATH: Month: November; Day: 2; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9-26-90

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry WORK

14. MOTHER'S MAIDEN NAME: Mary JUDGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral arterial thrombosis, multiple — INTERVAL BETWEEN ONSET AND DEATH
332X
DUE TO (b): Generalized atherosclerosis — 24 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from April 13 1959 to Nov. 2 1960, that (I) (we) last saw the deceased alive on Nov. 2 1960, and that death occurred at 10:10PM, from the causes and on the date stated above.

22a. SIGNATURE: L. G. Muth M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11-3-60

22c. PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-7-60
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town, or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphrey
ADDRESS: Pumphrey Funeral Home, Bethesda, Md.

25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12736 **CERTIFICATE OF DEATH** 12851

Item 14, Film G-281 2/21/61.cac

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, Md
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 3404 Purdue St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1659-2

3. NAME OF DECEASED (Type or print): First: Guy; Middle: NMN; Last: Webb
4. DATE OF DEATH: Month: 11; Day: 25; Year: 1960
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-17-09
9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - Navy Dept.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Guy Webb, Sr.
14. MOTHER'S MAIDEN NAME: Helen Gray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: wife, Fidelia M. Webb — Address: 3404 Purdue St. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b): Myocardial Infarction — 2 hours
DUE TO (c):
420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955, 19__, to Nov 25, 1960, that (I) (we) last saw the deceased alive on Nov 25 1960, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Leon L Gallin MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11-25-60
22c. PHYSICIAN'S NAME (Type): LEON L. GALLIN
22d. ADDRESS: 7206 Colesville Rd., Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-29-60
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION (City, town, or county) (State): Wheaton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co — ADDRESS: 5801 Cleveland Ave Riverdale Md.
25a. REC'D BY REGISTRAR: DATE NOV 29 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Trama

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12880 **CERTIFICATE OF DEATH** 12852

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4629 Hunt Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: W — Last: White
4. DATE OF DEATH: Month: November — Day: 18 — Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/23/88
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months 11, Days 25 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (State or foreign country): Avon New York
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Herman Wright
14. MOTHER'S MAIDEN NAME: Ella Cooke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Benjamin White — Address: 18 Peacock Farms Rd. Lexington, Mass

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hypoxia — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b) Cerebral Thrombosis — 2 days
DUE TO (c) Cardiac Failure — 2 hours

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma left Breast, Surgical Release
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955 to Nov 18 1960 that (I) (we) last saw the deceased alive on Nov 17 1960 and that death occurred at 10:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/18/60
22c. PHYSICIAN'S NAME (Type): Stewart Clapp
22d. ADDRESS: 4740 Chevy Chase Dr. Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11/19/1960
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Prince George Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: NOV 22 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

- - - - -

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12737

CERTIFICATE OF DEATH

12853

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: ?

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Eventide Nursing Home

d. STREET ADDRESS: 1753 Kilbourne Place N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LORA — Middle: — Last: WHITE

4. DATE OF DEATH: Month: Nov. — Day: 13 — Year: 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/23/76
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George White
14. MOTHER'S MAIDEN NAME: Kathryn Lowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Edward White-1753 Kilbourne Pl.N.W. — Address: Washington, DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Debilitation — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs.
DUE TO
(b) generalized Arteriosclerosis — 5-10 yrs.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 13, 1960, to Nov 13, 1960, that (I) (we) last saw the deceased alive on Nov 13, 1960, and that death occurred at 11:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W B Wardrop MD — M.D. ☒ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS.
22b. DATE SIGNED: 11/13/60
22c. PHYSICIAN'S NAME (Type): W. B. WARDROP M.D.
22d. ADDRESS: 800 PERSHING DRIVE SILVER SPRING Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 11/16/60
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town, or county) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: Washington, D. C.
25a. REC'D BY REGISTRAR: DATE NOV 15 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

CERTIFICATE OF DEATH

Reg. Dist. No. 12854

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4½
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Silver Spring
d. STREET ADDRESS: 18011 Eastern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Barrett; Middle: Y.; Last: Williams
4. DATE OF DEATH: Month: 11; Day: 12; Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-14-1893
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government Employee
10b. KIND OF BUSINESS OR INDUSTRY: Post Office
11. BIRTHPLACE (State or foreign country): Germantown Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Zachariah Williams
14. MOTHER'S MAIDEN NAME: Vandelia R. Soper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 214-03-0505
INFORMANT: Ruth Williams Sabelee (niece) Address: 5105 W. Franklin Richmond Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, posterior Septal. — INTERVAL BETWEEN ONSET AND DEATH: 5
420.1
DUE TO (b): Arteriosclerosis of Coronary Arteries
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 7, 1960, to Nov 12, 1960, that I last saw the deceased alive on Nov 12, 1960, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Michael R. Dobridge M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave Silver Spring Md. DATE SIGNED: Nov 13, 1960

PHYSICIAN'S NAME (Type): Michael R. Dobridge

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/15/60
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901-14th St. NW
24a. REC'D BY REGISTRAR: DATE NOV 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12882 **CERTIFICATE OF DEATH** 12855

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 SILVER SPRING
d. STREET ADDRESS: 10210 MENLO AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HELEN Middle LOUISE Last WILSON
4. DATE OF DEATH: Month Nov. Day 6 Year 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/23/14
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C.C. Analyst
10b. KIND OF BUSINESS OR INDUSTRY: Rexon Electronics
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: William F. FAUVER
14. MOTHER'S MAIDEN NAME: Edith M. Edmondston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 527-26-3750
17. INFORMANT: Son Robert (Same as Item 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure
DUE TO (b) Hepatic Necrosis (?Viral)
DUE TO (c)

580 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Tumor of Rt. Adrenal Cortex

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/27 1960 to 11/6/60 19 that (I) (we) last saw the deceased alive on 11/6/60 19 and that death occurred at 12:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John O Robben M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Nov 7, 1960
22c. PHYSICIAN'S NAME (Type): JOHN O. ROBBEN
22d. ADDRESS: 1015 Springvale S.S. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 11/9/60
23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY
23d. LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeska — WARNER E. PUMPHREY, INC. ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR DATE NOV 14 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12883 **CERTIFICATE OF DEATH** 12856

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda,
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 102 Chevy Chase Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert Middle E. Lee Last Wiltberger
4. DATE OF DEATH: Month Nov. Day 23 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 15, 1866
9. AGE (In years lost birthday): 94 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist
10b. KIND OF BUSINESS OR INDUSTRY: Medical
11. BIRTHPLACE (State or foreign country): Washington D. C
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Wiltberger
14. MOTHER'S MAIDEN NAME: Mary Borah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Wife Mrs. Virginia Wiltberger (same) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident — 5-10 mins
DUE TO (b) Cerebral atheriosclerosis. — ?
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized atheriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from 15 Nov 23 19 60 to Nov. 23 19 60, that (I) (~~we~~) last saw the deceased alive on Nov 23 19 60, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: George A. Gray, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/23/60
22c. PHYSICIAN'S NAME (Type): Geo. A. Gray, Jr. M.D.
22d. ADDRESS: 4740 Chevy Chase DR. Ch. Ch. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/26/60
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: NOV 28 '60
25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12752

CERTIFICATE OF DEATH

Reg. Dist. No. 12857

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2809 University Blvd. W.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 2809 University Blvd. West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELSIE — Middle — Last WINKLER

4. DATE OF DEATH: Month 11 — Day 11 — Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/14/92
9. AGE (In years lost birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Christian Treffeisen
14. MOTHER'S MAIDEN NAME: Maria Salomea Koch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hugo Winkler — Address: 2809 Univ. Blvd. W. Kensington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Anemia — 6 months
DUE TO (c) Carcinoma of rectum — unknown

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1960, to Nov. 11, 1960, that I last saw the deceased alive on Nov. 10, 1960, and that death occurred at 9 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Eino Magi — M.D. — ADDRESS (Street, city or town, state): 918 University Blvd. E. — DATE SIGNED: 11/12/60

PHYSICIAN'S NAME (Type): EINO MAGI — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11/15/60
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY
22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. — Raymond A. Zeska — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE NOV 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12884 **CERTIFICATE OF DEATH** 12858

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050

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2

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Loudoun
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leesburg
d. STREET ADDRESS: Route # 1 837-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul; Middle: Millard; Last: Wolverton

4. DATE OF DEATH: Month: November; Day: 5; Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 15, 1945

9. AGE (In years last birthday): 15 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Perry M. Wolverton

14. MOTHER'S MAIDEN NAME: Mary Dutterer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: days

583X

DUE TO (b) Hepatitis, unknown etiology — months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Pulmonary Aspergillosis — weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 16 1960 to November 5 1960, that (I) (we) last saw the deceased alive on November 5 1960, and that death occurred at 8:46AM from the causes and on the date stated above.

22a. SIGNATURE: W. Anderson Spickard M.D. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 11/5/60

22c. PHYSICIAN'S NAME (Type): W. Anderson Spickard, Jr., M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8 Nov 60
23c. NAME OF CEMETERY OR CREMATORY: UNION
23d. LOCATION (City, town, or county) (State): LEESBURG Va

24. FUNERAL DIRECTOR'S SIGNATURE: MUSE & REED by Stanley Reed
ADDRESS:

25a. REC'D BY REGISTRAR DATE NOV 9 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

12859

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: North Carolina — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kinston
d. STREET ADDRESS: 1006 Harvey Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jesse — Middle: Pugh — Last: Wooten, Junior
4. DATE OF DEATH: Month: November — Day: 24 — Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 3, 1944
9. AGE (In years Last birthday): 16 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Student)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Jesse Pugh Wooten, Senior
14. MOTHER'S MAIDEN NAME: Harriett H. Tull
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gram Negative Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 1 Week
204.3
DUE TO (b): Acute Lymphatic Leukemia — 1 Year
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 30, 19 60 to November 24, 19 60, that I last saw the deceased alive on November 24, 19 60, and that death occurred at 10:05a M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward E Morse M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 11-24-60
PHYSICIAN'S NAME (Type): EDWARD E. MORSE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 11-24-60
22c. NAME OF CEMETERY OR CREMATORY: BURIAL-TRANSIT
22d. LOCATION (City, town, or county) (State): KINSTON, N. CAROLINA
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: NOV 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12886

CERTIFICATE OF DEATH

Reg. Dist. No. 12860

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Bethesda
d. STREET ADDRESS: 1 5106 Manning Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene — Middle: B — Last: Young

4. DATE OF DEATH: Month: 11 — Day: 10 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/7/1885
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Ockershouser
14. MOTHER'S MAIDEN NAME: Mary Baker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
INFORMANT: Thomas B. Young, Husband — Address: same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular collapse — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
(b) carcinomatosis — 3 months
DUE TO
(c) metastatic adenocarcinoma of breast — 2 1/2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Feb., 1956, to Nov. 10, 1960 that I last saw the deceased alive on Nov 10, 1960, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilfred R. Ehrmantraut M.D. — ADDRESS (Street, city or town, state): 4890 Battery Lane — DATE SIGNED: Nov 10, '60
PHYSICIAN'S NAME (Type): Wilfred R. Ehrmantraut MD. Bethesda Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/12/60
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14 St N.W.
24a. REC'D BY REGISTRAR — DATE: NOV 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12701

CERTIFICATE OF DEATH

Reg. Dist. No. 12861

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: --
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Marilea Sanitarium — 14511 Colesville Road, 6B Research Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
d. STREET ADDRESS: 6B Research Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

16 67-2

3. NAME OF DECEASED (Type or print): First MARGUERITE — Middle SLUYTER — Last ZABRISKIE

4. DATE OF DEATH: Month Nov. — Day 5 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 1, 1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Grand Rapids, Michigan U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John G. B. Sluyter

14. MOTHER'S MAIDEN NAME: Meintje Eleveld

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: Yes

INFORMANT: Myron L. Zabriskie, Address 6B Research Rd., Greenbelt, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO
(b) Generalized arteriosclerosis
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 2, 1960 to Nov 5, 1960 that I last saw the deceased alive on Nov. 5, 1960, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John S. Rogers, M.D.
ADDRESS (Street, city or town, state): 1919 Sweeney Rd. Silver Spring, Md.
DATE SIGNED: Nov. 6, 60

PHYSICIAN'S NAME (Type): JOHN S. ROGERS — 1919 Sweeney Rd., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 9, 1960

22c. NAME OF CEMETERY OR CREMATORY: South Church Cemetery

22d. LOCATION (City, town, or county) (State): Bergenfield, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. CHAMBERS CO., Riverdale, Maryland.

24a. REC'D BY REGISTRAR — DATE: NOV 9 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58